Role of the Pathologist on the Hospital Staff
How and Why of Hospital Landscaping
Planning Diagnostic and Emergency Facilities

July
VOLUME 69 NUMBER 1
1947

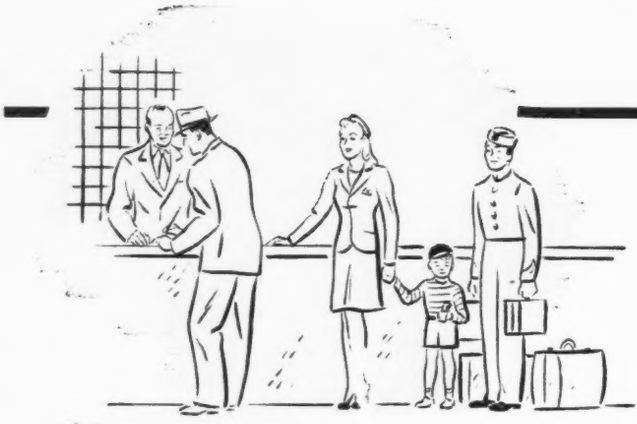
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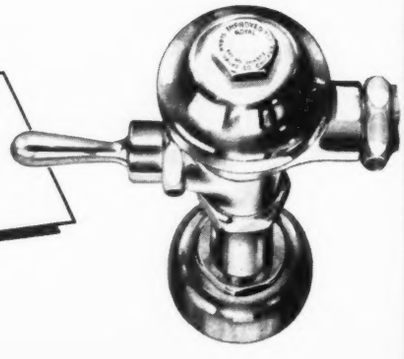
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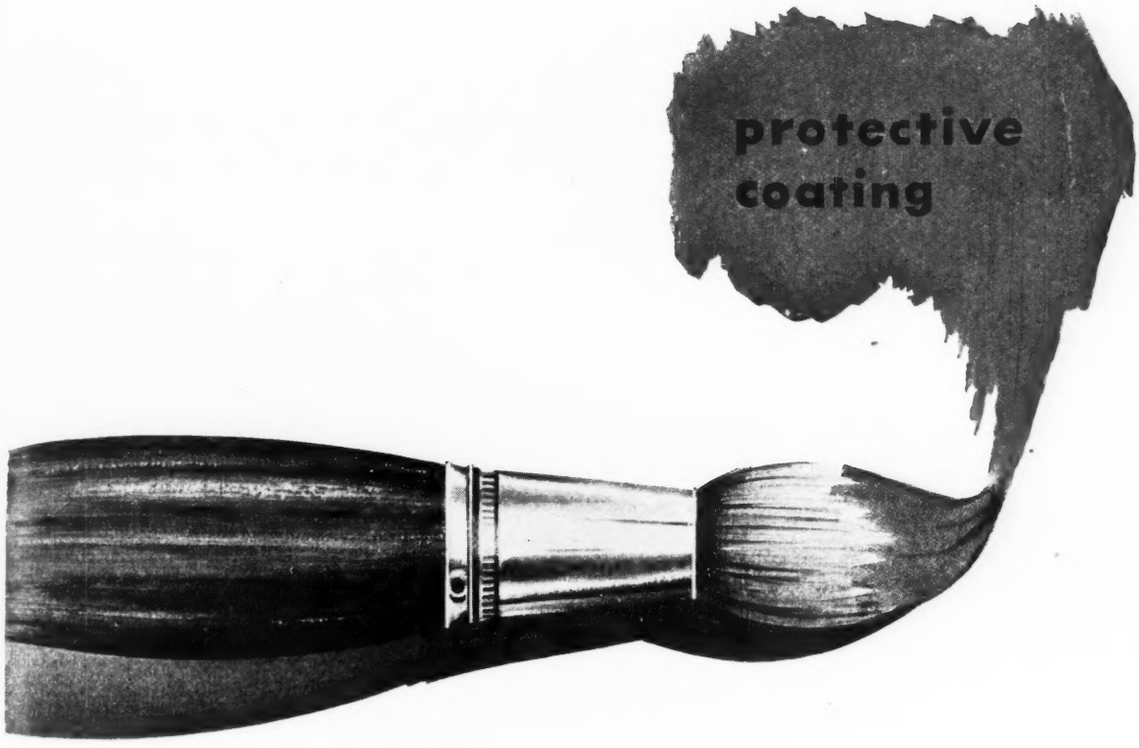
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This Month

WE INTRODUCE. . . .



People who think the principal qualifications for a consultant in landscaping are a strong back and a green thumb will be astonished at the career of **Garrett Eckbo,** who studied landscape design as an undergraduate at the University of California and, later, in the graduate school of design at Harvard University. Before going on to Harvard from the University of California, however, Mr. Eckbo had a year of what he refers to as "very practical experience" in the landscape department of a Southern California nursery. After receiving the master's degree in landscape architecture from Harvard in 1938, Mr. Eckbo worked for a while on various projects in the East, including a turn in the office of Norman Bel Geddes, then returned to California and spent several years developing site plans and landscape designs for rural housing projects and other types of community facilities, including the hospital described in his article on page 46.

Homer J. Baransy entered the hospital field by the ambulance entrance. While he was a patient in a sanatorium at Colorado Springs he helped out in the clinical laboratory and x-ray department. In 1932 he got a job as technician at Soldiers Hospital, Sulphur, Okla., where he stayed for six years in various management capacities. Then he went to the Sulphur Hospital as administrator, a position he held until the Northwest Community Hospital was opened at Mooreland, Okla., in 1943. As administrator, Mr. Baransy often fills in as pharmacist, technician, engineer or admitting clerk as the situation demands. This, he maintains, is one of the chief joys of the small hospital, where such quick changes often are needed. Nevertheless, he confesses that there are times when he wishes he were running a small peanut stand on top of a high mountain.



Margaret Howell Fisher is record librarian at Mercy Hospital, Urbana, Ill., where she has been ever since she switched from a business career six years ago, yielding at last to the fascination for hospitals she felt as a little girl performing surgery on her dolls and having it performed on her as a repeat patient with mastoiditis. Mrs. Fisher had forgotten all about her yen to be a nurse and was happily embarked in the business world when another hospitalization experience revived her hospital ambitions, with the result that she quit her job, went back to school and became a medical record librarian. That she meant business is amply demonstrated by the fact that, in addition to holding down her present job, she has appeared on hospital convention programs and written a workbook for record room procedures which is soon to be published. Her lively, thought provoking article on page 52 is additional evidence that she is in her present profession for keeps.

George Gray Ward, M.D., is professor emeritus of obstetrics and gynecology at Cornell University Medical College in New York and chief surgeon emeritus of the Woman's Hospital there, which he took over and reorganized when he joined the staff nearly 30 years ago. He is a graduate of the Long Island College of Medicine and a diplomate of the American Board of Obstetrics and Gynecology.



About ten years ago, when hospital bulletins consisted largely of financial and statistical statements surrounded by lists of persons to whom the hospital was grateful for gifts of cash, crab apple jelly and back issues of magazines, the Strong Memorial Hospital at Rochester, N. Y., issued a report which told the hospital's story in readable, dramatic terms, liberally illustrated with the pictorial symbols which have since become so popular. Designed by **Raymond T. Rich** of New York, this report was among the first of many projects he has undertaken in the health fields. Among the others: the recent public relations survey for the American Medical Association and an organization study of the national nursing groups. During the war, Mr. Rich suspended his activities as a public relations counselor to serve with the O.F.F., O.C.D. and Office of Inter-American Affairs in Washington.

Now a member of the staff of the Bergen County Hospital, Ridgewood, N. J., **I. Uyeda, M.D.,** has an all-American background: He was born in the Pacific Northwest, went to college in the Middle West, attended medical school in the Old South, served his internship in New England and a residency on the Atlantic Coast. A graduate of Tulane University School of Medicine in New Orleans, Dr. Uyeda wrote the article which appears in this issue because he thinks there is an unhealthy attitude between doctors and nurses. "The doctors themselves are not completely free from guilt in contributing toward the alarming nurse shortage," Dr. Uyeda contends.



To the argument about the applicability of army hospital experience to civilian hospital administration, **Frank M. Cameron** adds a positive, firsthand note: It applies. Mr. Cameron's army duties included personnel, nursing, medical records and corpsmen training; he served in medical units of all sizes, from 10 to 2000 beds. On his discharge from the army, he decided on a career in hospital administration and enrolled in the hospital program at Northwestern University in Chicago, from which he was graduated with the B.S. degree last month. During the course of his studies, Mr. Cameron was employed in the Children's Memorial and Grant hospitals. In the latter institution, he helped to install a stores control system similar to the one he describes on page 50.



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THE ROVING REPORTER

To Smoke or Not to Smoke

One hospital in the Chicago area is studying a lesson learned recently in the enforcement of its nonsmoking rule for student nurses.

At the time the school of nursing was built extra dollars were invested in the installation of laundry and trash chutes from the living floors to the basement. These chutes were costly but should have paid for themselves quickly by eliminating the necessity for hauling trash and laundry down five floors in some instances.

That the saving was not realized is due to that age old problem—human nature. The school of nursing had a nonsmoking rule for students. Did that stop the student nurses from smoking? Brother, did you go to school?

But violation of rules is carried, even by the courageous, just so far when the penalty of being caught is expulsion. Result: Every time an authoritative step was heard, down the laundry and trash chutes went the cigarette of anyone standing in the halls.

Have you ever seen a forest fire? A combined linen and trash fire in the basement of the nurses' building was just as spectacular and, according to this hospital, just as costly. Short of stationing rangers in the basement there was nothing to do but permit smoking or wire up the chutes. Guess which was done.

It's an Economic Asset

Your hospital may be making little or nothing of the fact that it is an economic asset to the community as well as a health asset.

Silver Cross Hospital, Joliet, Ill., recently devoted an issue of its house organ, *Silver Linings,* to describe the hospital as a business enterprise and a large consumer of both labor and commodities.

A hospital, Silver Cross pointed out, is a magnet that draws from a wide area customers for itself and relatives and friends who come to visit them. These people become users of local transportation facilities and shoppers at stores and oil stations. The hospital attracts doctors and nurses to the community and its professional staff constitutes a large group of high class consumers and civic minded citizens.

Most of the hospital supplies are purchased locally, as are building materials for remodeling and new construction. Hospital construction projects provide employment for local labor.

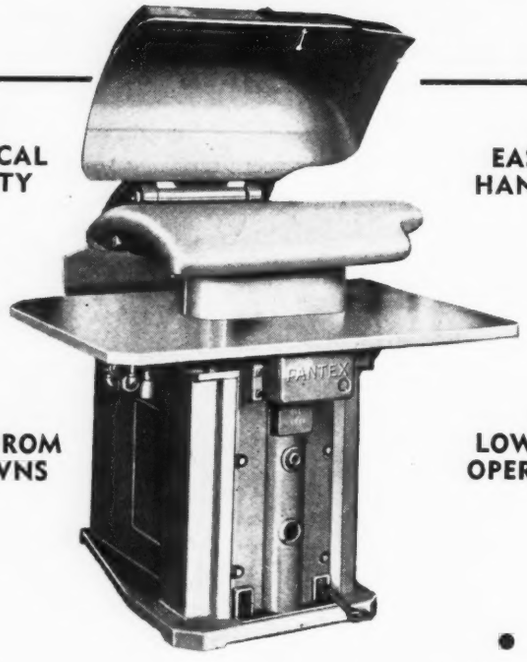
Moreover, the availability of adequate hospital service means better health for business and industrial employes and less absenteeism and inefficiency on the job resulting from ill health. From the standpoint of local merchants, the hospital in reducing the loss of income caused by sickness increases purchasing power.

Told with illustrations, as it has been done by Silver Cross Hospital, this is a good story.

Visiting Hours for Florists

A rose is a rose is a rose in the hospitals of Montclair, N. J., only between the hours of 1 and 3 p.m. so far as deliveries are concerned. Same goes for

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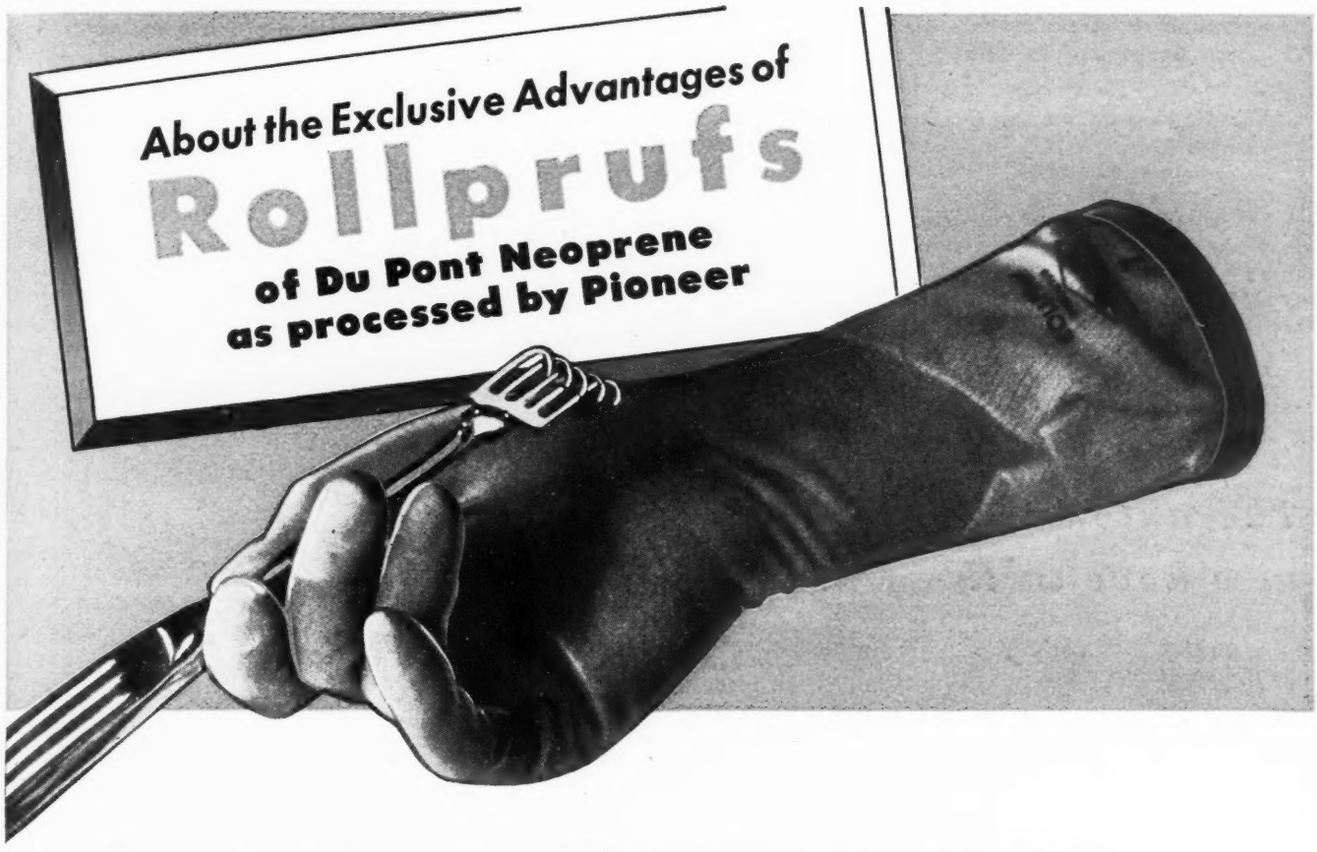


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These gloves offer the surgeon unusual finger-tip sensitivity

MANY doctors have reported their discovery that Rollpruf Surgical Gloves of neoprene give them notably greater finger-tip sensitivity than gloves of natural rubber. The Pioneer processed neoprene, soft of texture and tissue-sheer, apparently has unique ability to transmit "feel" to the surgeon's fingers — but without sacrifice of the durability and protection expected of a surgical glove.

This is so important a quality that every surgeon will want to check it for himself.

In trying neoprene Rollprufs you find they give you also unusual finger freedom, are less cramping to the hands, fit snugly without wrinkles and because of the flat-banded cuffs, will not roll down to annoy during operations. Also they are apparently free of the natural rubber allergen which causes dermatitis.

These advantages are highly desirable, if true. It pays to prove them for yourself, as many hundreds of hospitals have done. Order some from your supplier — or write us if he doesn't have them. *The Pioneer Rubber Company, 240 Tiffin Road, Willard, Ohio, Los Angeles.*



Rollprufs of Latex

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Quixams of Neoprene

Either-hand short wrist examination glove, now made of finest quality neoprene. Any two is a pair — less cost.

A Discovery About Neoprene

Neoprene must not be confused with synthetics used in tires. Pioneer's 9 years of experience with it prove its extraordinary advantages in a surgical glove. Besides, neoprene stands contact with oils, petrolatum or acids that damage rubber.

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tulips, stock, chrysanthemums and other cut flowers and plants from florists.

Mountainside, Community and St. Vincent's hospitals in Montclair got their heads together, or rather the heads of Mountainside Community and St. Vincent's got together, and decided to limit deliveries of flowers to conserve employes' time. The florists, it turned out, were happy to cooperate for it cut down on the number of deliveries they were expected to make to hospitals. Now the patients get their flowers with a minimum delay after receipt at the hospital for the work schedules are set up to handle the posies promptly.

Mileage Record

Twenty million miles in fourteen years, that's how ambulances travel. If you think that is the total mileage of all hospital ambulances, that's where you are fooled. It is the record set up by ambulances belonging to one hospital only.

Probably the most extensive ambulance service in the nation is that of the University of Iowa Hospital. Its 20 ambulances traveled the 20,000,000 miles on Iowa roads during the period mentioned, carrying patients to and from their homes.

Iowa has 99 counties and at least one ambulance visits each Iowa county five times a week. Some 20,000 state patients are carried yearly. In 1945-46, Supt. Gerhard Hartman reports, a saving of $45,000 resulted from the use of the ambulance fleet instead of other means of transporting patients.

The University of Iowa Hospital is anticipating the day when it can have radio telephone service between it and the ambulances on the highways.

Edited by Engineer

Congratulations to St. Luke's Hospital, Milwaukee, on its new house organ, *St. Luke's News*. It may easily be the only hospital publication in the country edited by a mechanical superintendent—and a good job he and his staff are doing.

John Banasiak, the mechanical superintendent, proposed an employe publication at one of Administrator Merton Elihu Knisely's regular sessions of department heads, so straightway he was named editor.

One of the strong points of the paper is its brand of humor. No joke book repartee, this, but unpretentious and entertaining accounts of events under the hospital roof.

For example, "One Night in a Hospital Laundry" recounts the sounds that prohibited slumber for four employes marooned in the hospital by a big storm last February. Stretched on mattresses on the large laundry tables, the men were scarcely soothed by the hourly clicking of the sewer pumps, the gurgle and hammer of the heating lines, the hissing of the hot water tank valve and the accelerated ticking of the water meter as on 143 occasions between midnight and 6 a.m. a toilet was flushed up stairs.

The *News* has a column listing "Cardiac Cases," it being about equally divided between employe engagements and marriages. All employe birthdays of the month get advance notice in a box labeled "Many Happy Returns."

St. Luke's house organ is a mimeographed job ("stencil duplicated" one is supposed to call it for the manufacturer of mimeographs does not like its trade name loosely used). Mr. Knisely will probably send anyone a stencil duplicated sample copy for the asking.

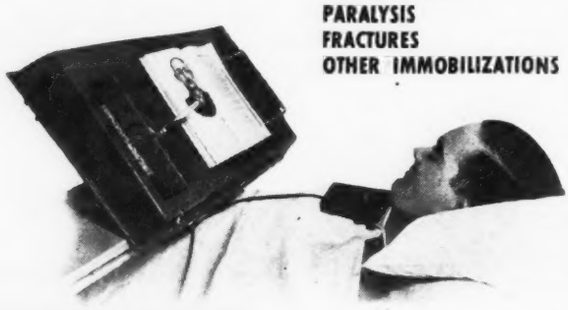
He Gives His All

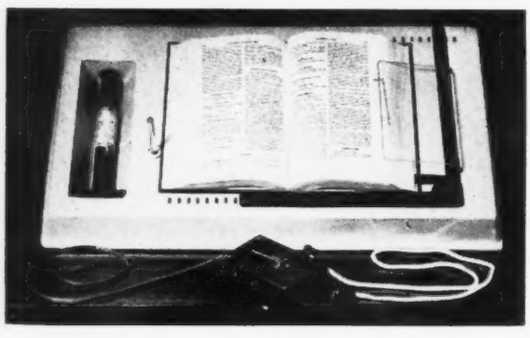
Good patients' relations paid off at Morristown Memorial Hospital, Morristown, N. J., when Dale Jensen, who has been a patient in the institution for a year and a half, contributed his two bank accounts to the hospital building fund.

Dale Jensen is 3½ and his two piggy banks yielded 1300 pennies. Upon the advice of his parents, Dale allocated the $7 out of the spotted pig to the new outpatient clinic building and the other $6 savings account to the pediatric ward.

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READER OPINION

And "Chicken Every Sunday"

Sirs:

I was much interested in the article "Labor Problems Are Still With Us" by Mildred A. Kent in The Modern Hospital for May, especially in the comment that: "We might well ask ourselves: Do we concentrate too much on the 'scientific' responsibilities of our work, such as the therapeutic diets, well balanced menus, teaching nutrition and diet in disease to student groups and so forth, and not give enough attention to serving really good food? Hospital dietary departments, given modern equipment and reliable well trained employes and using business-like and efficient methods, should be able to produce as good food as that obtainable in successful restaurants." Is it entirely a matter of equipment and employes?

No finer contribution has been made and is being made by any department in my hospital than by the dietary department.

I agree that the dietitians have oftentimes accomplished the impossible during the times of food and personnel shortages. The personnel shortages are still here.

To my mind, second only to poorly cooked food is the poorly planned menu. There is an example in a recent issue of The Modern Hospital of the type of menu that causes dissatisfaction. Maybe this is "International Month," for I note it starts on the first with Spanish rice, then Italian spaghetti; in nine days we have all this and noodles, cheese and mushroom casserole and macaroni and cheese, too, all for supper.

Perhaps the president of the Blank Tuna Fish Canneries is a trustee of the hospital and is having his appendix out, for I note that on the 20th we have a tuna and noodle casserole for supper, on the 22d we have tuna, rice and cheese casserole for supper. How come we skipped a day? Now I am not president of the cannery and maybe I don't like fish.

The war is over and pineapple is in, so the week of the 20th in this hospital is National Pineapple Week. So we have pineapple in a salad for supper on the 20th; the next day we have pineapple upside-down cake for dinner; the next day we have pineapple in cocktail (the only kind of cocktail we can get and I approve 100 per cent); there is some left so we finish up the last of the pineapple the next day for breakfast.

Well, that's over! The pineapple is gone, nothing left but a little juice drained off which we can use for breakfast on the 28th. So from the 23d to the 30th inclusive: "What do you say, let's open some cases of something else; nix on the pineapple."

I love cheese, too, but everyone doesn't. If I want to serve cottage cheese ad infinitum at home, that's fine, but watch your tricks at the hospital—don't hide it inside a prune, that takes time, too, and don't try to hide the hole in the pineapple ring. We know the facts of life, we know the prune pit shouldn't be there, might go down the wrong way when we are flat and helpless; we know the pineapple slice has a hole in the center. So when the help has nothing else to do they scoop out tomatoes, good, good expensive tomatoes so there will be room to hide whatever happens to be around, usually cottage cheese.

What started early ambulation? "Doc, I can't take it any more, get my trousers and shoes quick before that tray girl comes in; get me out of here. I'm going nuts guessing and I'm always right and I don't get $64."

Well, the Docs and some of the patients are lucky; the help are optimists—they ambulate, too, and how; they try it here and they try it there.

For the faithful ones who stay on the job, try a little variety. You won't have to do any more work. Watch out for your calendar of memories; dodge national spaghetti and macaroni weeks. "Thursdays is sauerkraut," "Tuesdays is meat loaf," and "Chicken every Sunday" is funny in a book or on the stage, but not in the hospital. Give us a break.

Mabel W. Binner
Administrator
Children's Memorial Hospital
Chicago

Drill Was Unnecessary

Sirs:

Shortly after the wreck of the Red Arrow, we had another smaller train wreck and were planning for a disaster drill on Hospital Day in which we expected the Red Cross to cooperate as well as other agencies in the city. On May 1 there was another train wreck near Huntingdon and we received 29 patients for treatment that day. In view of the fact that there have been so many recent catastrophes, we felt a disaster drill this year would be rather superfluous.

I hope next year to put on a full scale rehearsal of some sort.

Robert L. Gill
Superintendent
Altoona Hospital
Altoona, Pa.

SMALL HOSPITAL QUESTIONS

Conducted by Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Me., and others.

Surgery After Hours

Question: Here is our major problem at the present time.

Some few of our physicians who have recently returned from the armed forces have no conception of doing surgery within routine hours. They come out in the evening after 7 p.m. and decide to do work which could be done between 7 a.m. and 7 p.m. These off hours necessitate calling a nurse back on duty after her hours have been spent in the hospital.

This is injustice to the hospital staff, to the patient and also to the hospital routine. If it were not for the critical shortage of nurses we might work out something for the off hour surgery, but we try to do no surgery other than emergency after 3 p.m. because we usually have to call some nurses back on duty. We pay time and a half for overtime, but the nurse prefers to have her time off for rest instead of drawing the extra pay.

We are wondering if there are any standard rules that would back our regulations in not posting any surgery after 3 p.m. other than emergencies.—L.B., Tex.

ANSWER: I would certainly urge that you work through your chief of staff, or chief surgeon, in establishing satisfactory regulations regarding nonemergent surgery. However, I feel that one of the underlying difficulties in our hospitals has been the tendency to crowd all surgery, all x-ray and other time consuming procedures into a short four to five hour period, when it is entirely possible to space them through the day, permitting a better distribution of personnel.—WILLIAM J. DONNELLY.

Placing the Formula Room

Question: Would you kindly advise me as to the best location for a formula room in a 75 bed hospital?—P.F., Me.

ANSWER: In the small hospital the formula room may be located in either the dietary department or the maternity section. Its location is the subject of some difference of opinion on the part of clinicians and administrators.

Advocates of the dietary department location hold that preparation of formulas is properly the dietitian's responsibility and therefore the formula room should be located near the kitchen. The maternity specialists feel that because they are most directly concerned with the welfare of the newborn infants, the formula room should be under their supervision on the maternity floor. This, it is said, assures formulas that are sterile and minimizes handling of bottles. When a separate pediatrics department exists, many pediatricians feel that the formula room should be under their direction.

Assuming that the care in preparation of formulas would be equally good whether the dietitian or the maternity personnel were in charge, the discussion seems to boil down to the question of handling the bottles. Locating the formula room in the maternity section, of course, would cut down carting and handling to a minimum and, also, emergency feedings would be immediately at hand.—MARSHALL SHAFFER.

Admit the Emergency Case

Question: Is it a good public relations policy to require registration of maternity patients within three months from beginning of term? Also, how about refusing to take any type of emergency case when all beds are full, even though it may be possible to put up extra beds? These questions are especially with reference to "community" hospitals, not institutions in large city areas.—R.H.D., Pa.

ANSWER: It is desirable to require registration of maternity patients and this registration can allow for an initial contact by the hospital in the form of a letter to the patient acknowledging the registration and enclosing an information booklet. I should seriously question the wisdom of refusing an emergency case when it is possible to provide a bed. Certainly, the community expects its hospital to make the extra effort necessary to take care of this emergency patient regardless of the inconvenience occasioned by his admission.—WILLIAM J. DONNELLY.

Encourage Hospital Insurance

Question: Should a nonprofit hospital take care of its employes free of charge, paying for expensive medicines and treatments? When the employes carry insurance should the hospital receive the insurance money or should it be paid to the employe?—M.W.L., Ga.

ANSWER: In the old days hospitals provided free hospitalization in lieu of adequate salaries. Today it is advisable for the hospital to encourage the use of Blue Cross and medical and surgical insurance by supporting these plans through the enrollment of its staff even to the extent of paying the cost for this protection in full according to the family status of employes.

Our hospital provides medications for the use of employes without charge and allows for the purchase of medications for his immediate family at cost. There has been absolutely no abuse of this privilege and it has, in fact, been a source of good will toward the hospital.—WILLIAM J. DONNELLY.

Remuneration for Radiologist

Question: What plan is most commonly followed in connection with the remuneration for a consulting radiologist who does both diagnostic and therapeutic work in a hospital? If there is no one plan used oftenest, a discussion of several that are in common use would be of interest.—W.L.D., S. D.

ANSWER: There is no single plan of providing remuneration for a radiologist. I suggest that you review the principles outlined in the American Hospital Association bulletin, "Principles of Relationship Between the Hospital and Radiologists, Anesthetists and Pathologists," covering the several plans approved by the American Board of Radiologists, the American College of Surgeons and the American Hospital Association. The arrangement adopted should provide for safeguarding the interests of the radiologist, hospital and patient. Too often one or another of the three interested parties is exploited at the expense of the other two.—WILLIAM J. DONNELLY.

Away From Ceiling Lights

Question: What is considered to be the most economical and satisfactory lighting for patients' rooms, operating rooms and corridors? Are fluorescent lights being used in patients' rooms?—P.F., Me.

ANSWER: The inquirer will find a survey of current trends in hospital lights and lighting in an article in the May issue of The MODERN HOSPITAL.

Briefly, it is not believed at present that ceiling or wall hung fluorescent lights should be used in patients' rooms. The trend is definitely against any ceiling lights in these areas. In private rooms, a good floor lamp is desirable. Careful consideration should be given to the use of the removable bed or wall bracket type of light that is so designed that it can be used not only for reading but also as an examining light.

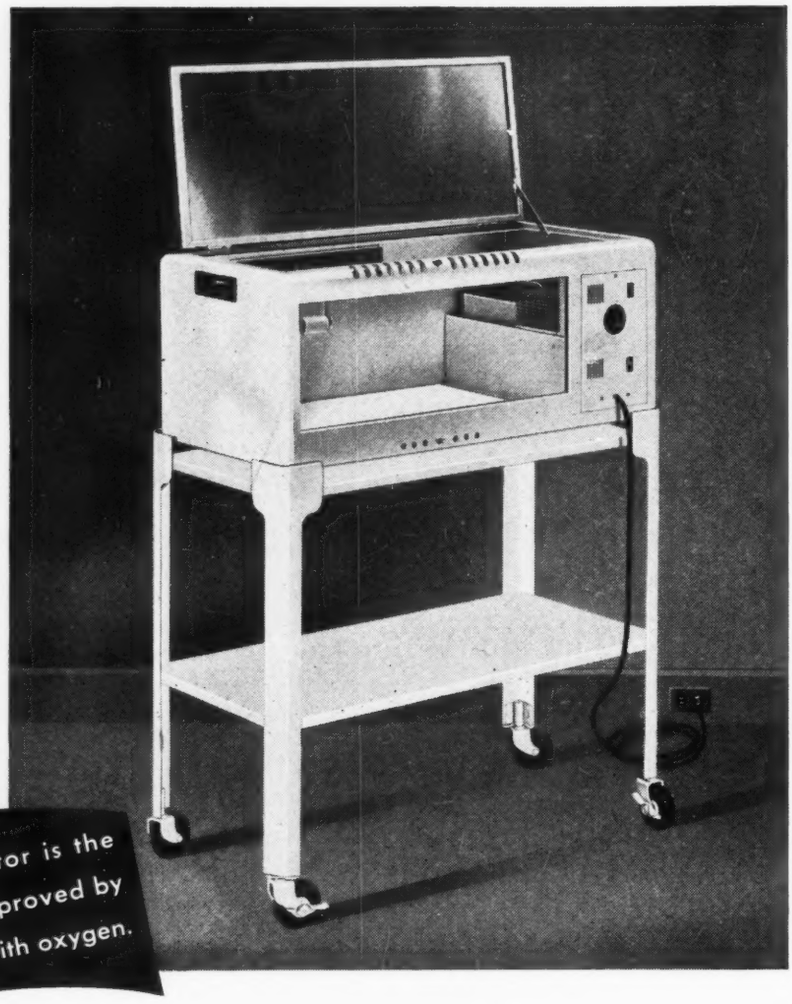
Fluorescent lights are considered especially valuable for use in corridors where lights have to be kept on a large portion of the day.—E. W. JONES.

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LOOKING FORWARD

Worse Purse Makes Nurse Terse

HOSPITALS and nurses are taking an awful beating up in the magazines. An entry called "Don't Curse the Nurse," in *Collier's* for May 31, for example, began with some tear-jerking tales of hospital patients who waited a matter of hours for needed nursing service, then telephoned home to beg for help. Not cursing the nurse, much, the *Collier's* essay referred to nurses as, among other things, mean, curt, heartless and old curmudgeons.

Whatever is wrong with nurses, it develops, is not so much their own fault as it is that of the hospitals, which are giving them a terrible financial and spiritual shellacking and rubbing their noses in arduous, laborious, humdrum ward work. Hospitals are "economic wastelands" with "horse and buggy personnel arrangements." Nursing schools are like concentration camps.

These sunny views are echoed in an article appearing in the June issue of *Magazine Digest*. "Why Student Nurses Don't Graduate," by Eric Hutton, plays a sinister variation on the concentration camp theme with a series of lurid anecdotes about student nurses who were sacked, docked or picked on for coming in two minutes late, wearing a ring or lipstick on duty or just not being meek enough.

Thoughtful hospital and nursing people are understandably upset by articles like these, which give the impression, intentionally or not, that all or most hospitals are like the minority which is guilty of the sins described. A grain of truth thus becomes a mountain of injustice; millions of readers are getting a dim view of hospitals and the nursing profession. Hospitals will lose some support as a result, and nursing will lose some students.

Fortunately, public opinion is formed in small part by what people read and hear, and in large part by what they actually experience. Hospitals which are treating students and nurses fairly and giving patients good service will not suffer from publicity which says they aren't; everybody whose opinion counts knows better. Hospitals which are shoving nurses and patients around, however, and unquestionably there are some, may expect to get burned in the fire they helped to start.

Sooner or later, somebody is bound to write an article about a nurse who is happy. In the meantime, the best answer to articles like those in *Collier's* and *Magazine Digest* is not to scream murder but to get busy casting beams out of eyes.

Lay That Pistol Down!

THE radiologists are marching against the Redcoats! "Corporate practice" is the militant rallying cry as they gather forces for an assault on their oppressors, the hospitals. The battle will soon be joined, and it will be pursued until the slaves are all freed of the cruel bonds of salary and can send out bills with their own names on them.

Like the Corcyreans pleading at Athens, the radiologists are soliciting stronger allies to join the righteous cause. "If we are totally without means of preventing the employment and exploitation of radiologists by incorporated hospitals," declares the 1947 *Bulletin* of the American College of Radiology, "then there is nothing in the world to prevent them from employing and exploiting practitioners of other specialties.

"Leaders of medical thought are beginning to recognize an area of basic conflict between organized hospitals and organized medicine," the *Bulletin* continues, driving the point home. "They have begun to weigh the issue: Shall medicine be practiced by private physicians or by hospital corporations? Perhaps they have realized that socialization is not the sole, or even the greatest, threat to a free and unfettered medical profession.

"Organized medicine," the *Bulletin* concludes darkly, "can no longer ignore insidious changes in the functions of hospitals that, unless checked, will undermine the very structure of American medical practice."

If this array of strength opposes them, the prospect for hospitals looks grim indeed. But wait! Don't shoot yet, men! The hospitals have a hostage—one whom neither the radiologists nor their putative allies wish to harm, but who will surely get hurt if these forces are turned loose.

We call him the patient.

Is This Meeting Really Necessary?

EXHIBITORS at hospital meetings have frequently expressed the wish that exhibits could be limited to the large regional meetings and that displays at individual state association meetings could be discontinued. It doesn't pay, these people have stated repeatedly, to ship their exhibits and send their sales personnel to the

state meetings, where a comparatively small number of prospective purchasers will see the display and few if any orders will be taken.

Why don't the exhibitors stop going to state meetings, then? If it really doesn't pay, some hospital people ask, why don't they just quit? And until they do quit, why shouldn't the state hospital associations use this means of financing their meetings?

At first glance, these seem to be reasonable questions. Looking at the individual exhibitor's situation, however, one can quickly see what a spot he's in. It will cost Exhibitor A a lot of money and effort, for example, to send his display to the Catawba State Hospital Association meeting, and on past performance he knows that he won't begin to get his money back in business, either actual or potential. The Catawba secretary, however, is on his toes and points out enthusiastically that there will be a rich pay-off in "good-will."

He probably doesn't realize it himself, but what the secretary is saying is, in effect, "Brother, if you want to do business with the Catawba crowd, you'd better come on in!" Fearing that if he resists the pressure and stays out, Exhibitor B, a competitor, will jump in and play the advantage for all it's worth, A goes along.

The cost of taking space and sending exhibits to state meetings is added to the price of the manufacturer's product and, eventually, to the cost of hospital care that is paid by the public. It might be argued that the public would pay the ultimate bill for state hospital meetings anyway, since hospitals themselves would have to underwrite costs now paid by exhibitors, so there is nothing much to be gained by changing the present system. The fact is, however, that if hospitals were paying the bills themselves instead of passing them along to exhibitors, state meetings would soon be boiled down to real essentials.

There isn't any sense in making a state association meeting a two or three day carbon copy of regional and national meetings, with the same speakers doggedly covering the same old subjects and the audience wearily telling itself, "This is where I came in." Most of a state association's business can be dispatched in a single afternoon and evening, if indeed there is any reason at all for bringing the whole membership together. Some states have found that the needs of members can be served best by affiliating with one of the existing regional assemblies and eliminating state meetings except for officers and trustees. The American Hospital Association might be wise to divide the whole country into regional areas and urge other states to follow suit.

Until something like this is done, the waste and duplication of separate state association meetings will probably continue. So will the polite form of blackmail under which exhibitors get stuck with the bill.

Get Everybody Into the Act

I'VE seen hospital kitchens in which nine or 10 people couldn't turn out the work five or six might do in the same space properly laid out," a hospital authority said recently. As every experienced administrator knows, the same thing could be said of many other hospital departments.

To avoid mistakes and oversights in planning, most administrators and architects seek counsel at every possible point. The series on functional planning now running in The Modern Hospital has been helpful to many and will continue to serve for years as a standard reference work on the subject. Specific advice from architects and consultants who make a specialty of hospital planning is another way of making certain that 10 man kitchens won't be built for five man service.

Still another method, and one which is most frequently overlooked, is to consult the hospital's own departmental staff. "Give the nursing staff, including head nurses of wards, a peek at the plans," is the way one administrator has expressed it, "and ask for suggestions. Nurses *work* in the areas outlined, and a few, at least, would have a real contribution to make. Also, it should give them a feeling of belonging—good personnel relations."

These are words of wisdom. The administrator seeking practical advice in planning an addition or new building can certainly profit by looking down as well as up, organizationally speaking.

The method offers one other advantage. The head nurse or dietitian or housekeeper who is working in an area or department she helped to plan will be fully accountable for efficient operation of that department.

Home Care

AT A TIME when it is progressive to talk about making the hospital the focal point for community health and concentrating all types of health service within the hospital's walls, a voice speaks up to suggest that it may also be sensible to send the hospital home with the patient.*

On the face of it, there are many economies in a program aimed at freeing the many hospital beds occupied by patients who do not require all the specialized facilities the hospital is geared to furnish. On the other hand, organization through the hospital as a central agency of all the medical, nursing and social services that many bed patients at home need but do not always get seems a sensible way to extend the effectiveness of professional workers over broader areas. Under such a plan, the doctor can serve a larger number of patients at home, with better assurance that his instructions will be carried out as he intends them to be, and save the hospital beds available to him for the acutely ill patients who have to be hospitalized.

The hospital which has introduced this program is ideally situated to carry on an experiment of this kind. The plan will be watched and studied with interest by thoughtful hospital people everywhere; it holds rich possibilities for making the hospital the focal point of community health in fact as well as in name.

*Cherkasky, Martin: Hospital Service Goes Home. Mod. Hosp. **68**:47 (May) 1947.

Truth Must Be Served—With Tact

When the Pathologist Sits in Judgment

The thoughts presented here about the rôle of the pathologist on the hospital staff were developed by the pathologist at a large teaching hospital in conversation with a member of the editorial staff of The MODERN HOSPITAL.
We believe this doctor has done some clear thinking on a difficult subject and that these thoughts throw some light on the complicated relationships that exist among the pathologist, the staff, the administrator and the governing board. For that reason, we are presenting them here in article form.—*The Editors.*

THE pathologist occupies a unique and highly important position in any hospital. He is the person who sees tissues and organs removed at operation and who examines them and makes the final anatomic diagnosis. He is the one who also examines the bodies of those who have died in the hospital and whose final diagnoses are most generally accepted because they are based upon actual examination of organs and tissues.

Because of his opportunity to make intimate examination and study of the actual organs and tissues affected by disease, the pathologist is placed in the position of being able to make more nearly accurate diagnoses than is the clinical practitioner. But, just because his diagnoses may sometimes, and by no means always, differ from those of the clinician, it is not possible to draw the conclusion that the clinician has been careless or inaccurate or is in any way reprehensible.

The more nearly accurate diagnoses of the pathologist are based upon the opportunities he has to study organs and tissues more closely than it is possible for the clinician to do. The latter must make his diagnosis as a result of carrying out various examinations which do not include actual observation of the deeply seated organs of the body. To use a homely illustration, the clinician is like the man who must try to tell the nature of the contents of a closed box by making various kinds of tests which must not include the opening of the box. The pathologist may be likened to the man who can open the box and examine its contents.

On the other hand, the pathologist sometimes finds that a diagnosis which a capable physician certainly should have been able to make from the examining methods available to him was not made. That is the time when the clinician may be held culpable.

Just what the pathologist should do when genuine errors in diagnoses or in clinical judgment are made and have been discovered in the course of his studies is a problem which I have never been able to solve satisfactorily. Perhaps at the present time there is no good solution to this problem. Should the pathologist go to the physician himself and discuss the matter? This can easily be done with some clinicians and they not only understand but appreciate comments the pathologist makes.

Should the pathologist discuss the matter with the medical chief of staff or with the head of the department of the physician concerned? This question can be answered both yes and no, the specific answer depending upon the sort of men who happen to be chiefs of staff or department heads. In some cases, the matter might be handled tactfully and well and the offending clinician would learn as a result of his mistakes. In other cases, the information could actually be unduly harmful to the offending clinician and punishment far out of proportion to his mistake might be meted out.

Should the pathologist go to the hospital administrator with the in-

formation? I most certainly think he should if he feels that the hospital itself may be involved in any way. Sometimes mistakes made by physicians may actually deeply concern the hospital and it would seem that the hospital administrator should at all times be aware of the findings by the pathologist that might, in one way or another, involve the hospital in a lawsuit.

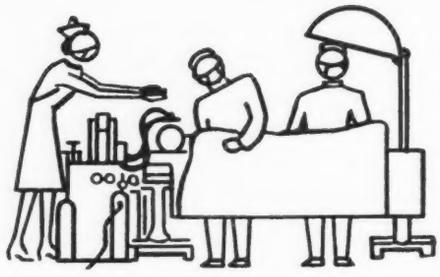
In large hospitals in which there are responsible medical bodies and committees, such as a medical board, professional errors can best be handled by such medical groups. In smaller hospitals in which the administrator plays an important part in running the medical affairs of the hospital, perhaps he is the person who should take up the matter directly with the physician concerned.

Should Be Referred to Physicians

If, however, the administrator happens to be a lay person, not a physician, the problem becomes a delicate one, because it may lead to an outright break between the administrator and the entire medical staff. Moreover, injustice might be done, because evaluation of the severity of the mistake not only is difficult to make but is sometimes actually impossible. I therefore believe that in such cases the matter should be decided by a responsible senior physician or a body of physicians, not by a layman or a group of laymen.

Just how a pathologist can advise concerning the quantity of surgery done in a hospital is also difficult to determine. So many questions enter into a decision to operate on a patient that the pathologist, who rarely sees the patient before the operation, is really not in a position to say whether or not the operation was necessary. After it has been performed and he has had an opportunity to examine the specimen or specimens removed, he may be able to express an opinion, but the opinion is not of much value in single cases.





If, after a considerable period of time, he is able to say that Doctor A performs a large number of operations which seem to him to be unnecessary on the basis of pathological specimens submitted for examination, then I think Doctor A should be talked to by someone. Who that someone is must be worked out in each specific case. Preferably, he should be a physician. It would also be well if that physician occupied some official position, such as chief of staff, department head or some similar position. He could then speak with authority to the offending doctor.

If Doctor A persists in performing operations which seem to be of doubtful necessity, then it seems to me that the hospital administrator and the board of trustees must enter the picture. They should, however, be advised not by one physician but by several, preferably a group like a medical board, and at no time should it appear that action is being taken against any physician by a nonmedical administrator or nonmedical trustees without the full and complete approval of some sort of advisory medical board.

I say this because I think that it would be most inadvisable to condemn any member of a hospital staff solely on the basis of a pathologist's report. The pathologist's report should first be received, studied and concurred in by a group of other physicians.

As far as the quality of surgery performed in a hospital is concerned, the pathologist is not always a good judge. It seems to me that a senior surgeon, or better, several senior surgeons, should be the judge of the quality of surgical work done by the members of the hospital staff.

Human nature being what it is, it is always going to be difficult for a hospital pathologist to play the part of a professional judge of the work of his clinical associates without difficulties and misunderstandings arising. The pathologist himself may be unfair or may perhaps have a personal grudge against a physician. This will tend to warp his judgment. On the other hand, clinicians may misunderstand the motives behind the pathologist's actions and may condemn him unjustly.

It is never easy, and sometimes never possible, for the pathologist to put himself in the place of the attending physician. The physician must have foresight. The pathologist, by virtue of the opportunities he has to study tissues and organs removed from the body, has the advantage of hindsight. Hindsight is always better than foresight. For that reason, the pathologist can do more to help his clinical associates to profit from errors they may have made by thoughtful discussion than he can by condemning them. He may, if he is friendly and tactful, do much to elevate medical and surgical standards by the observations he has been able to make.

Some Welcome Criticism

I strongly oppose the attitude that the pathologist should carry a big stick and be ready to beat down clinicians on any provocations. I feel that the pathologist should instead be helpful to the clinicians with whom he works. He may have to be careful about the way he tries to be helpful. Some physicians resent being talked to, others welcome comments and helpful critcism. If the pathologist can get clinicians to come to his laboratory to discuss matters, perhaps he can then give his most helpful service.

To offset his adverse criticism, I think he should attempt always to commend good work or to do or say something that will indicate approval rather than disapproval. In this way the effect of adverse criticism may be toned down and all his criticisms may prove more helpful.

I. UYEDA, M.D.
Bergen County Hospital
Ridgewood, N. J.

IT HAD TO HAPPEN SOMETIME!

A Doctor Speaks Up for the Nursing Profession

THERE is a strange relationship manifest between doctors and the nursing profession, a relationship that is difficult to explain inasmuch as both have the same goal and must necessarily work constantly together. The medical profession, in general, is unusually severe toward its closest companion, the nursing profession. Too many physicians and hospitals are still entangled in the cobweb of notions that modern nurses are nothing more than glorified maids. They fail to see the harmful implications of this point of view which boomerangs to strike at the efficacy of the treatment given their own patients.

Pushing Them Farther Down

Too often we hear of doctors' demands that nursing school curriculums be slashed far below the standard requirement in order to keep more nurses on the floor. The present nurse shortage has greatly increased this myopic point of view among doctors. Instead of making the nursing profession more attractive they are thrusting it even farther down into the category of a profession in which drudgery, long hours and thankless orders already exist to an intolerable degree. The doctors and hospitals have only themselves to blame for the increasing shortage of nurses that is threatening the country.

Recently a headline in a Boston paper read: "Nurses Called Too Educated." The occasion was the reporting of a talk by one of the country's eminent surgeons.* The general theme of the talk was that nurses are "legislating" and "educating" themselves out of jobs. Similar implications have been made in medical and hospital journals. These would make it appear that doctors are deliberately preventing improvements in the nursing profession.

No one can blame the present nurse shortage and the declining nursing school enrollments on the difficulty of the nursing school curriculum or on the nurses' "excessive" knowledge or "high" salaries. The truth is just the opposite. The prospect of only ward routines without adequate instruction will definitely keep away many intelligent students from the nursing school. In addition, poor pay and long hours *are* keeping away many potential students.

The nursing curriculum is equivalent to a college education. Modern hospitals and doctors depend a great deal upon the alertness of the nurse to forestall impending dangers. Quick action on the part of a nurse, based on years of training and accumulated knowledge, frequently prevents irreversible disasters. This responsibility is great.

During the training period, work on the wards is for the purpose of helping the student become thoroughly familiar with the application of knowledge gained in classes. Running a modern hospital ward requires a great deal of basic knowledge of the diseases and of methods of managing them. Doctors expect the nurses to be familiar with them. Three years spent in nursing school is a training and just that; therefore, the foremost objective is toward instructing the nurses, not just using them on the wards for back rubs and distributing medicines and meal trays.

Bedside technics are important, but they must be backed up with knowledge of the nature of the illness. If one is interested only in having someone carry trays and make beds, three years of training are not necessary. However, a doctor who is seeking a special nurse for his acutely ill patient will prefer to have a nurse who is "on her toes" because of her knowledge of the disease.

One may even go a step farther and say that there is not enough variation in the nursing curriculum. The nursing school as an institution of higher education should look toward a broader education for the nurses. The idea is sound that in colleges students learn how to think and obtain a liberal education in order to become better informed citizens. Such a liberal background should also be given to the nurses. Some nursing schools require a college degree as prerequisite to admission; others require two years of college work plus three years of nurses' training to obtain a bachelor of science degree.

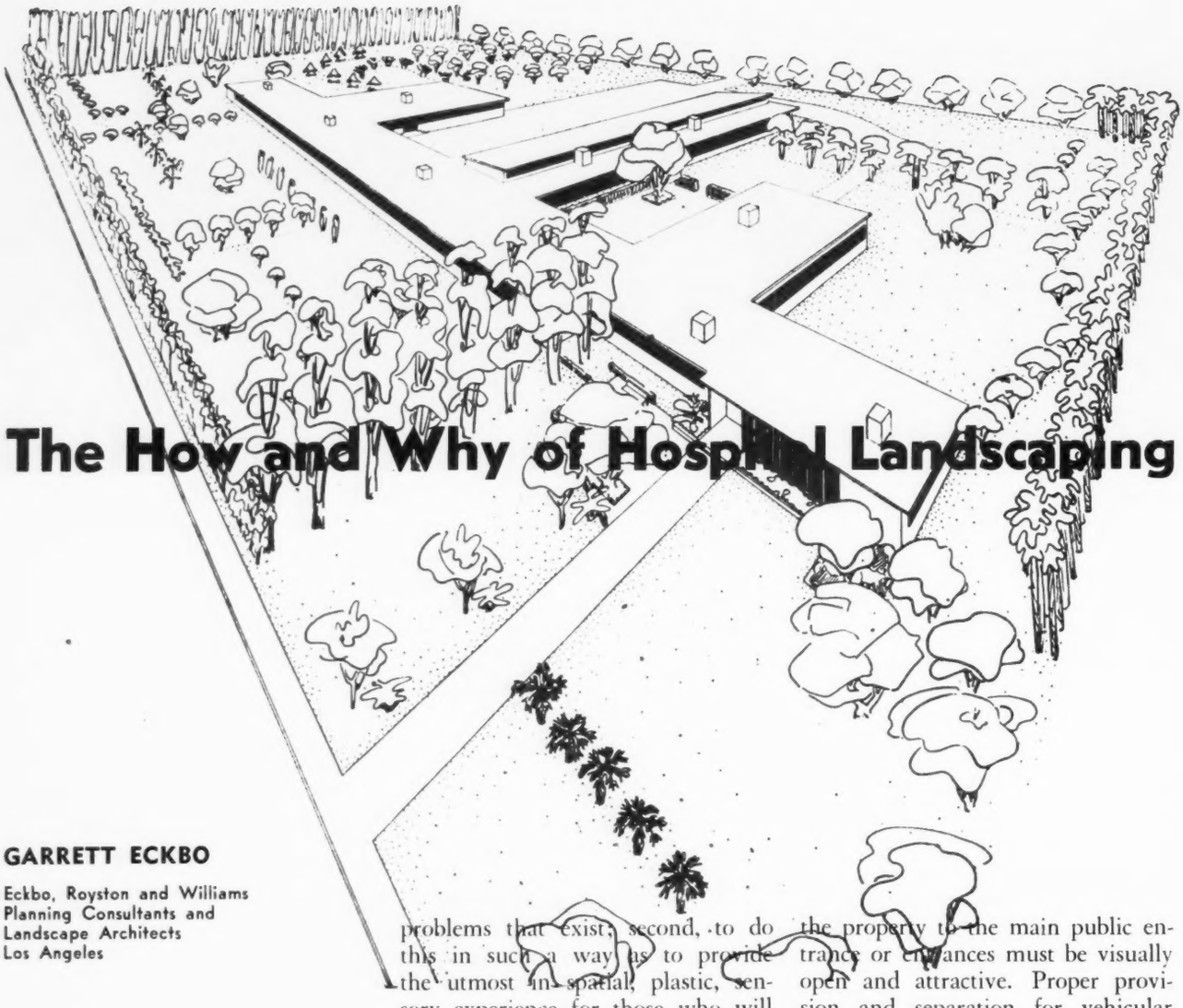
No such extensive curriculum could be contemplated in a nursing school, but a few elective courses in nonnursing subjects can well be offered in the nursing school. They will serve as a diversion from the purely scientific studies. The entire objective is to give nurses an opportunity for as well rounded an education as possible.

Poor Instruction—Poor Service

Many hospitals, especially those removed from the large medical centers, are finding it increasingly difficult to recruit doctors to teach the student nurses. This, again, is completely contrary to the welfare of the doctors themselves. Physicians who give poorly prepared courses to the nurses are harming themselves. By turning out poor quality nurses they will obtain poor quality service for their own patients. The community doctors are largely responsible for the quality of nurses graduated from their local hospitals.

Nursing is an integral part of modern medicine; improving this part will improve the whole. The time and energy a doctor puts forth in the instruction of nurses are investments that pay good returns.

*Dr. Frank H. Lahey. Address to public health conference, sponsored by the Boston City Federation of Organizations, Inc., at the Y.W.C.A.



The How and Why of Hospital Landscaping

GARRETT ECKBO

Eckbo, Royston and Williams
Planning Consultants and
Landscape Architects
Los Angeles

THE normal assumption as to the function of landscaping around the hospital—or any comparable large public building with grounds around it—seems to center, once certain practical problems of access, circulation, service and screening are solved, on concepts suggested by the terms "beautify," "provide a setting" for the building, and "tie it to the ground" with foundation planting.

In other words, it is a kind of exterior decoration. I hope to suggest here an infinitely broader, richer, freer and more organic approach to this problem of landscaping the public building, such as the hospital, with considerable or ample open grounds around it.

First, what are the responsibilities of the landscape architect (professional, commercial or amateur) who is entrusted with the design of such development? Simply these: first, to solve all the practical and functional problems that exist; second, to do this in such a way as to provide the utmost in spatial, plastic, sensory experience for those who will frequent the space; third, to accept the need for continuous reasonable scientific experiment aimed at broadening the limits of this experience and maintaining tradition by continuously expanding it.

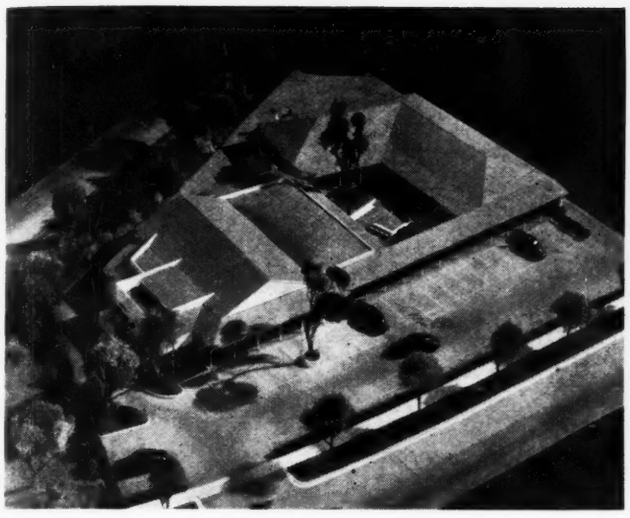
Now what is the problem with which the landscape architect is confronted in a hospital job in which the property lines are considerably more extensive than the building lines? The specific functional problems already mentioned, which require careful specific objective analysis, are a part of the overall general problem of establishing sound integration, both functional and esthetic, between the building and its entire site.

This means, first, that all access openings in the building must have properly proportioned and arranged connections with the outside world beyond the property lines. The outlook from all windows must be controlled and organized insofar as possible. The way in from outside the property to the main public entrance or entrances must be visually open and attractive. Proper provision and separation for vehicular and pedestrian traffic must be made.

Areas needed for service activities, *i.e.* clothes drying, garbage and trash disposal, and for outdoor recreational or therapeutic activities, games, sitting-out, sun bathing, must be properly placed and proportioned. The surface of the ground within the property lines must be placed under control, with planting or paving, in order to eliminate erosion by wind (dust) and by rain (mud). Proper screening of objectionable views, within or without the property, and protection from strong wind or sun are essential.

The solution of these functional problems is seldom enough in itself to supply the inspiration or basis for a full rich satisfying landscape scheme. Circulation and ground cover elements are two dimensional and inadequate as overall form determinants.

The whole esthetic problem of integrating the building, a rational, geometrical, man-made element, with





These two photographs illustrate methods of landscaping designed to relate the site-space to the mass of the building.

its site, an irregular, "natural" element, in terms of form and space, remains to be solved. It remains to be solved here at the conclusion of our functional analysis, and it remains to be solved generally at the conclusion of most landscape installation work.

With consideration of any kind of landscape development beyond the basic functional elements, one runs immediately full tilt into questions of theory and esthetics. To be sure, there are conventional kinds of planting which are acceptable and "done" —street, color, specimen, foundation and border or boundary planting. But all of these as commonly done follow mechanical and academic formulas, with insufficient analysis of the nature of the problem and the possibilities latent in the materials to be used. This superficial approach stems from a failure properly to evaluate and accept professional responsibility, and from the acceptance of a minor rôle as exterior decorator placing frills around buildings rather than the assumption of a major rôle as space organizer comparable to the architect.

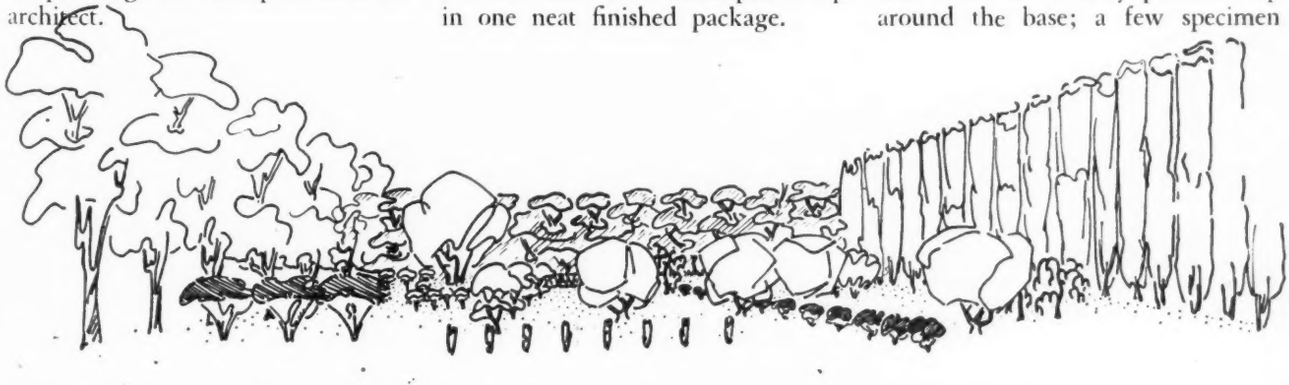
So what is the esthetic problem in the landscaping of any sizable public building such as a hospital? It is the giving of clear, coherent, functional rich form to all the three dimensional space within the site boundaries, accepting the beginnings of this form already developed in the site, building and circulation layout. Space is given form with tangible physical elements, and these can be anything from beds of ivy through hedges and rows of trees to structural rails, trellises, fences and walls.

It is only through the development of this space-form concept that the landscape architect can escape the futile rôle of exterior decorator. It is this landscape-space development which completes the overall form concept begun with the architectural and engineering plans, coordinates and integrates all the site elements and ties the whole development up in one neat finished package.

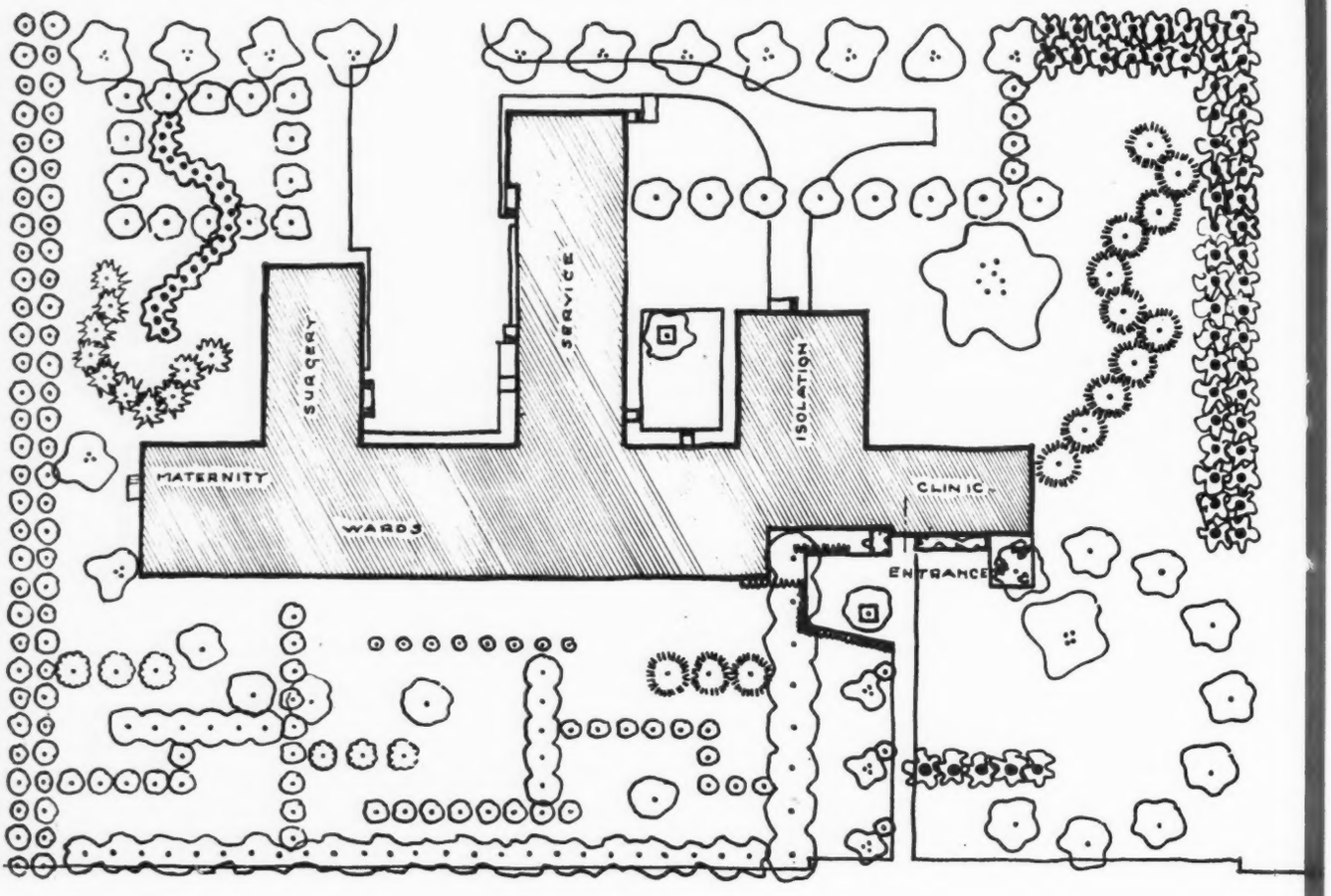
In doing this, it produces the final complete integration of buildings and site, structural and natural materials, man and nature. Needless to say this integration cannot be produced by the old process of choosing between "formal" and "informal." The only successful landscape development is that which is both formal and informal at once.

To the extent that this problem of complete space organization and coordination is not as much dominated by questions of specific functions, structural necessities and economics as is the architectural and engineering design, to that extent it is a more purely plastic and esthetic problem, requiring greater concentration on questions of pure form and material and approaching somewhat closer to painting and sculpture in the freedom of its form concepts.

The general problem of planting arrangement is ordinarily solved in the monumental, park-like or picturesque way: the building is treated as an object in a setting of verdure. The latter is carefully plastered up around the base; a few specimen



Opposite page and above: Landscape development of a rural hospital planned by the F.S.A. but not built because of the war.



The landscaping endeavors to reflect the clarity with which the main elements of the building, reception and clinic, general ward wing, service, surgery departments, are defined.

trees and shrubs are artfully spotted in the grounds around the building; perhaps a mall or allée is tied to the main entrance, and the whole entity is then turned loose to float quietly in a sea of green lawn.

There are variations from this treatment, but it is quite generally consistent. The external observer is favored over the insider looking out, and no attempt is made to develop the integrity of the entire site space as one coherent unit indoors and out. Building and site remain two distinct elements: the jewel and its setting, the mass and its base. This is a concept which has hung over from academic to modern architecture and which has helped neither. Great historic buildings with open space around them were carefully integrated with it.

In the various jobs shown as illustration we have endeavored to develop a really thorough and clear integration of building and site in terms of space, form, materials and function. Again, the introduction of the concept of site-space-form as of primary importance makes all the heterogeneous and unrelated elements fall together into a whole that is greater than their mere addition.

Trees and shrubs placed so as to form clear strong spatial relations with the building, and based on its form, achieve a quality and importance impossible when they are merely plastered against it or dotted about. Careful analysis of the way the building is used, which people it is important to, and how important it is places the outsider looking in and the insider looking out in proper relation to each other.

None of this statement is intended to eliminate broad lawns, specimen plants and fountains from use around public buildings such as hospitals, but only to suggest how the same elements can be used in a new, stronger, freer way to achieve a new level of experience and expression. It is felt that this approach, while derived from modern architecture, can produce a better environment for any building, no matter how academic its conception. We do not feel that the old argument between "modern" and "traditional" is any longer relevant.

Good modern design is a continuation of good tradition. The only choices involved are those between good and bad solutions of specific problems. Unless those problem conditions are very rigid we also concede the likelihood of several equally good solutions, by different designers, being possible.

Of course, the reader may well exclaim "Who cares about all this highfalutin site-space-form business? We just want our hospital to look nice!" And that is just what we want, too. The only point being made here is that we feel that hospital buildings can be made to look nicer than they ever have before, not only for the passerby in the street but, what is more important, for those who use the building every day.

Perhaps these ideas can now be best explained by an examination of the specific material presented as illustration. Let us take first the Farm Workers Hospital planned by the San Francisco District Engineers

office of the Farm Security Administration just before the war, but never built, because of the war. It will be noted that the main elements of the building, reception and clinic, general ward wing, service and surgery, are carefully and clearly articulated. The landscape development endeavors to reflect this clarity. The main entrance, with its semicircle of olives, wide walk and entrance court, shade trees, colorful smaller clumps and rock and sand arrangement, presents a wide and welcoming opening from the street. The break at the general ward wing is emphasized by a strong plane of tall white-trunked manna gums.

Beyond this the main lawn space is considered as primarily outlook from the ward windows, rather than as a foreground for the building viewed from the street. The strongest and tallest planting is concentrated at the property lines and feeds in toward the building in free irregularly geometric arrangements of lines and planes, employing such constrasting elements as Irish junipers, weeping mulberries and persimmons.

It is felt that this strong, orderly, yet irregular arrangement will create a greater sense of tangible space, and greater interest in and expression of the qualities of the materials, than will any weaker, more hodgepodge arrangement.

Must Be Related to Building

We feel that we cannot emphasize too strongly the need for giving strong, clear, rich form to the entire three dimensional site-space and relating it as closely as possible to the established mass and space form of the building. Whether or not the specific forms chosen to develop this idea on this specific job are completely successful is not as relevant as is the development of the idea. Landsape design vitally needs a concept of site-space-form. Without that it can only beautify and tinker with paper axial lines and naturalistic clumps.

The other building shown, an infirmary built at Vallejo during the war by the Federal Public Housing Authority, is developed with similar ideas on a smaller site. The Fourth Street side is a long blank wall on a busy traffic artery, and that side is planted primarily as a screen.

The photographs on page 47 are indicative of the character of development that these ideas have produced on other problems.

There is one other question to be considered: Will these ideas work for the large multistory hospital? Here the kind of planting developed for Fresno would serve not only as an arrangement of intriguing baffles at first floor eye height but as a three dimensional pattern or maze viewed from above. Certainly the success of the site-space concept as applied to taller buildings would depend upon the relation between height and distance to property line. As the height becomes greater and the distance gets shorter any landscape development will tend to become merely a decorative frill around the base of the building. This, of course, is merely a roundabout argument for adequate site space around hospitals and other sizable public buildings.

Finally, there is the question of landscape treatment on a rough or sloping site. Here a new problem is introduced: The earth must be treated as a sculptural material, with a pyramidal quality based on the angle of repose of cut and fill slopes. The site must be given form, with level and sloping terraces and curving slopes as needed, that will properly integrate the building form with the land on which it sits. Once these land forms are established, planted arrangements properly related to them and to the general site-space concept can be developed on them.

Goals for Graduate Nurses

THE Cleveland division of the National League of Nursing Education considers it necessary to:

ENCOURAGE the adoption of a 40 hour week so that nurses may have the time and energy to pursue cultural and professional development.

ESTABLISH a salary level which will enable a hospital staff nurse to maintain a standard of living equal to that of her friends in other phases of nursing or in other comparable professions.

MAKE POSSIBLE a broader contribution from the staff nurse by arranging for her participation in the planning of policies and procedures.

DIGNIFY the work of the staff nurse by providing assistance to carry the housekeeping and clerical types of duties.

STIMULATE interest in bedside care of patients by providing opportunities for study of advanced clinical nursing subjects, as well as intramural staff education programs.

INVEST the position of the bedside nurse with such prestige and provide sufficient compensation that it may be regarded as an end in itself rather than a stepping stone to another position, and that as a result the nurse who finds satisfaction in bedside nursing may continue to do it without excessive personal sacrifice.

These recommendations are based on the following beliefs:

1. That a stable group of graduate nurses is necessary for adequate care of the sick.

2. That the daily demonstration of skilled and intelligent nursing care by all graduate nurses is essential in the education of the student nurse.

3. That the graduate nurse happy in her work is the greatest force in student nurse recruitment.

4. That nurses as a group need reassurance of the value of their services for the administrative offices of civilian hospitals.

5. And that *now* is the time when all the foregoing factors are of particular significance to the status of the nursing profession as a whole.

Platform adopted by the Cleveland division of the National League of Nursing Education, March 11, 1947.

Index to a Central Stores System

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REGARDLESS of its size, every institution should have a central storeroom, even if it is only a closet. One individual should be responsible for receiving, storing and issuing all items to the various units.

Only with such a system can control be exercised over consumption, waste and efficiency in use of supplies and equipment. A reduction of expense can be noticed immediately after installation of such a control system if proper records are kept, while the difference in the total expense over the fiscal period will no doubt be amazing.

The next step after the installation of a central storeroom and the assignments of responsibility for its supplies is the establishment of maximal and minimal levels of these supplies. Through proper fixing of these levels according to use (the equivalent of three months' supply is considered a normal need) a reduction of inventory investment by favorable turnover of stock is possible and a simple routine for initiating purchases of stock items is begun—the start of a centralized purchasing setup without an elaborate system.

Once a record has been kept of the requisitioning and ordering of these supplies over a period of at least six months, and preferably a year, the planning of systems of further control may be considered. The great problem in such planning is in simplification and standardization of items to permit buying on quantity prices without overstocking the storeroom. In other words, maximum and minimum limits should be studied, keeping in mind the space available, the desired turnover and the economical purchase quantity.

Simplification consists of elimination of unnecessary sizes, varieties and brands of supplies that closely approximate or duplicate others and also those items that are used so seldom as to make questionable the value of storing them. Standardization is the setting up of specifications as to both dimensions and quality required for specific purposes so as to permit purchasing of substitutes at better prices while ensuring that the item will be what is required.

When these preliminary but necessary phases have been accomplished, a system of stock arrangement should be selected that is best adapted to the needs of the hospital, the qualifications of the personnel in the storeroom and the nature of the supplies. The objective is to achieve the greatest possible efficiency with the least amount of time and effort to stock and issue, requisition and keep the necessary records.

Basically, there are two types of shelf arrangement. In one type the shelves run horizontally with a central issue point. Shelves are back to back in rows separated by aisles wide enough to permit passage of a hand cart. This is perhaps the more flexible arrangement assuming adequate space to avoid crowding of passages.

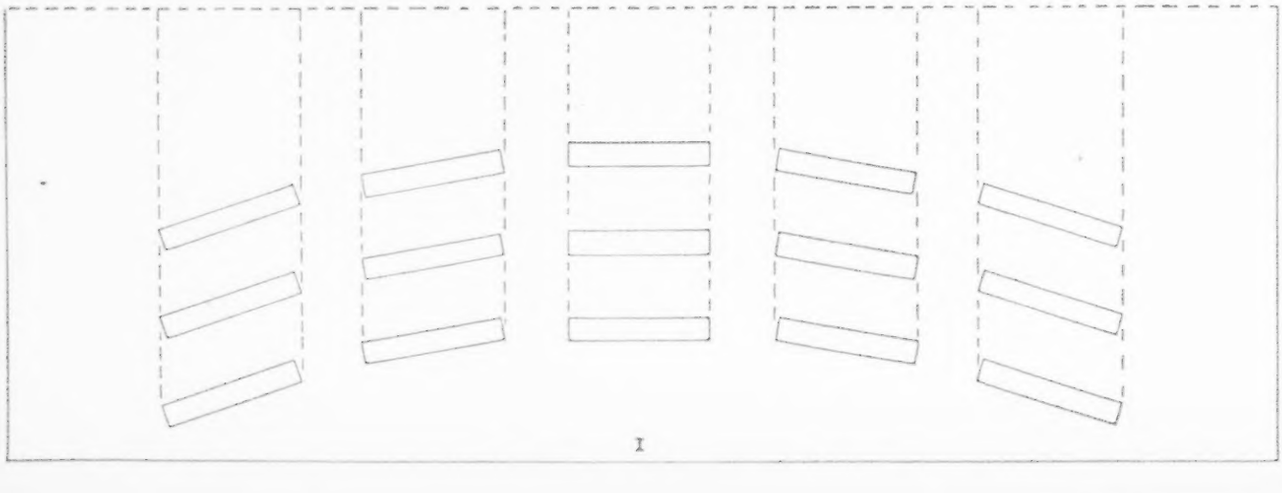
Another type is a vertical plan with the issue point depending upon the classification system used and the physical plan of the storeroom. Its inflexibility is primarily due to the fact that such shelves are usually run the length of a room and items stocked at the back are a considerable distance from the issue point. This may be true even in a rectangular room with the shelves arranged across its width if the room is large.

The next step is the classification and arrangement of supplies on the selves with an index system used for easy location and reference. Several such systems are in use but they are extremely detailed and cannot be described in this paper.

The first plan to be considered involves a classification and index strictly by location in that sections and shelves are numbered and items are placed according to some system and are cataloged in that order. The efficiency and flexibility of this plan depend upon the classification of items and upon their relative location in the storeroom.

Another method involves classification of supplies by the intrinsic nature of the items, *i.e.* metal, wood and paper. The difficulties of classifying many items will be apparent and yet this system has been used in

FIG. 1. SEMICIRCULAR ARRANGEMENT OF SHELVES AROUND THE ISSUE POINT.



the army and also in industry in classifying raw materials and their basic products.

Classification based upon departmental expenses of the accounting system is more functional and is advocated by many experts in the hospital field. However, a great many items are used by more than one department involving entries from one inventory account to a departmental expense account, thus increasing the possibility of error and the number of index numbers or inventory accounts that must be used. Because of this transfer, difficulty in classification is also encountered in setting up the stock. The functional relationship is limited by the natural recollection of individuals requisitioning or issuing according to departmental use.

A more truly functional index and classification has been used by industry and was developed even further during the war. Inasmuch as it is new to hospitals and needs modification to smaller stores, it will be described in more detail.

Because experts tell us that the peak of efficiency is reached within the radius of the operator this would indicate a semicircular arrangement of shelves about the issue point and running across the length of a rectangular room as shown in figure 1.

A location index would necessarily be used, each row and each section in the row across the room being labeled. Shelves would also be numbered but the item number would necessarily have to be flexible owing to the variation in size of items. Ideally, sections should be numbered as shown in figure 2, starting in the middle of the row with section 1; section 2 on the right; 3 on the left of 1; 4 on the right of 2 and similarly on out to the edges. The principle involved is again location nearest the issue point of the most frequently issued items. Practical considerations, however, may require that this point be waived.

To determine classification or arrangement of stores, the frequency of issue of each item (not the quantity of each item used but the number of times it is issued) over a given period that is long enough to cover issue of practically all items stocked, or about six months as a minimum, must be charted and items arranged on work sheets with the most frequently issued item first and others in diminishing frequency. This list then determines the fundamental arrangement of stores.

Actual arrangement on shelves is made by placing the item first on the list as Item 1 on shelf 1, section 1 in row 1. The index number for this item is then: 1111. Stock is then arranged in accordance with the list on shelf 1 and next on shelf 2; the index number for the first article on shelf 2 would be 1121.

This procedure is continued into the next section in numerical order to the end of row 1 and begun in row 2—and so on until all shelves, sections and rows or items have been completed. Space should be left, however, for possible additions to existing stock in their relative order of frequency, for such changes in the average institution will be continuous owing to substitutions, new products and changing purchasing policies.

The principle involved in such a system is amply illustrated by increased efficiency through the functional arrangement which diminishes the distance traveled and, therefore, the time involved in filling requisitions and refilling stock by placement of items most frequently used closest to the issuing point. The actual savings can be rather closely estimated, given the distances of items before and after arrangement in this pattern, the frequency of distribution and the average time taken to fill one requisition.

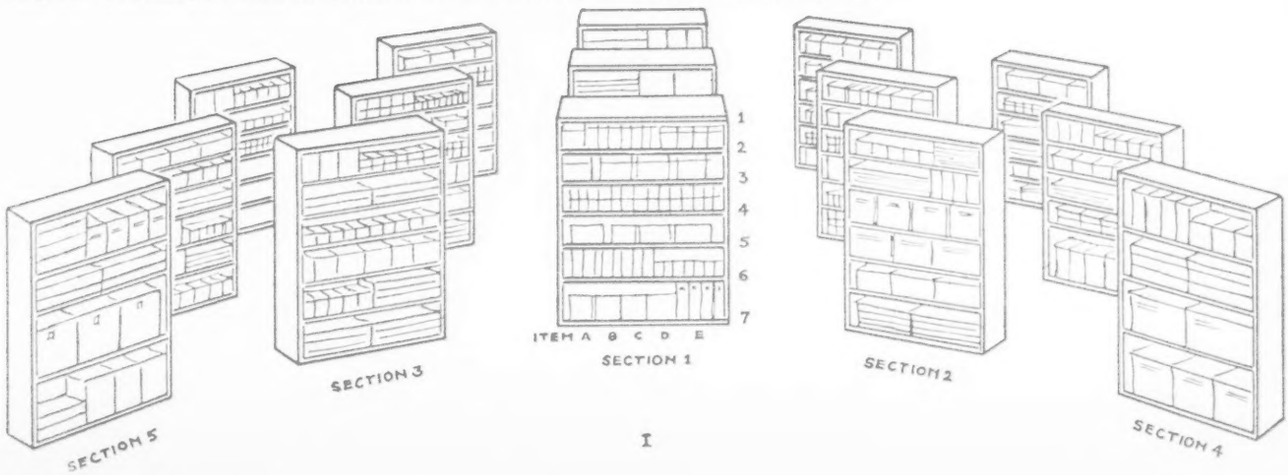
Figure 2 illustrates the storeroom arrangement and the method of locating stock. The item "A" with an index number would be located as shown on the sketch and it will be easily seen that the index numbers are a simple guide to location of stock.

The problem of location of stock too large to fit on a shelf without disrupting the smooth functioning of the system will necessarily make an exception to the arrangement. In the solution it must also be borne in mind that other items may be issued with such frequency as to make impractical shelf stocking rather than issuing directly out of the case, *i.e.* toilet paper.

In addition, other issues in case lots and such articles as brooms cannot be stocked on shelves. For these bulk items, then, a separate but integrated arrangement is required. One solution is to prefix this division with the last number of each row thereby making another section or two (each end of the row) in the proper general order of frequency of issue.

Owing to the highly repetitive nature of the first row or two, these items may be separated into departmental preprinted requisitions listing in proper sequence these most frequently requisitioned items in order to save time in the department. Practically, groups of departments may be included in one such requisition

FIG. 2. STOREROOM ARRANGEMENT AND METHOD OF LOCATING THE STOCK.



divided into "administrative," "nursing and professional" and "service" departments according to the natural grouping of items on such requisitions.

Separate catalogs for each of these groupings may also be prepared to simplify the requisitioning procedure through elimination of items not ordinarily used by one group which will reduce the number of pages and therefore unnecessary handling of unwanted pages. A less obvious purpose of such separation of catalogs is the reduction of indiscriminate requisitioning within the department of items which are seldom if ever actually used but which are often added to a requisition through mere curiosity or with some vague idea of a possible use.

The requisitioning procedure should be thoroughly explained to those who make out requisitions to ensure that the items are listed in numerical sequence according to storeroom and inventory card arrangement followed by the index numbers. Only in this manner can the stockman efficiently fill requisitions either in groups or singly and the inventory clerk work with cards without unnecessary jumping from drawer to drawer. Further, proper requisitioning sequence permits working with groups of requisitions both in the storeroom and by the inventory clerk in that all requisitions for one item can be handled at the same time.

The basic principle involved, then, is to increase efficiency by a functional arrangement through a frequency classification based upon a numerical location index to stock and to inventory cards.

In the large institution, an index based upon the number of requisitions processed per day or week may well serve as a control index to the work load and efficiency of either the stockroom or inventory clerk. Such controls may be devised in many routines, thereby saving a great deal of supervisory time and increasing efficiency by investigation only of variations from the normal.

Little Problems Are Big Headaches

to the medical record librarian

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FOR the last two years it has been my good luck to correspond with librarians in many parts of the country concerning the problems that confront those of us who are in hospitals of 150 or fewer beds. The mountainous difficulties that arise in these so-called molehills are of no small dimensions. I have come to the conclusion that if they are to be solved they must be brought out into the open and looked over with a critical eye by those people who deal with them from day to day.

In order to be sure that the problem existed in many places, a survey was made and the response was heartwarming. It is not the big problems of the daily routine that bother us; these we find worked out in the authoritative books that we possess. It is the small nagging ones that exist in our particular hospital.

This brings us into the category of the librarian working in the small hospital, who is not fortunate enough to have interns to write the histories and an aggressive scientific minded staff, and to the administrators who cannot say no to older employes who cooperate with the hospital very little and with the record room not at all.



It has been observed that the lack of understanding that exists at the conventions and institutes among the librarians of the larger hospitals and those of the small arises in one sense from the fact that they do not have our problems and we will never have theirs. One other observation is that if the librarians who attend the institutes and conventions would arise and speak for themselves during the round table discussions as whole heartedly as they do in the corridors and the coffee shops, we would have a jam session that would last all night.

On the other hand, if, when they do speak, those present who have gone forward through the years were not so bored and would remember that they, too, had a first day and a first year in the record room and that the newcomers, too, need a helping hand, it would help. And if they would only not present this timid new librarian with a trip through the deep freeze unit, we would then have a perfect setup.

For the solution of this problem, only two things are necessary: courage and courtesy. We in the small hospitals are usually the only registered librarians in the community or if there is another hospital the two are rivals and the association of the librarians is frowned upon.

I have endeavored to put some of these collected problems into groups. First there is the group of "how do you do it?" questions; then there are the problems of "inheritance" and of "administration-physician-departmental" relationships in regard to the record room.

Here are a few of the questions in reference to the first group, that come from all parts of the country. Of course, the first is: How do you get your records done? Reams are written about this every year, but in the small hospital it really is an acute situation.

Number 1 threat to the recalcitrant staff member is "the American College of Surgeons is coming." That can hold him only so long. And, oft-

times, if the A.C.S. field representative doesn't show up on promised schedule, he lapses back and gets to feeling that the A.C.S. is a benevolent spirit, somewhat akin to Santa Claus, who will ride by, pat us all on the head and say, "That's all right, Doc, I know you are busy."

Who's dreaming? The worst offender is usually some prominent member of the staff and the watchword in regard to handling him is, "Don't get him upset, take it easy." We do, he does, too; the result: 50 to 100 incomplete records.

How do you handle unethical requests from insurance agents as to information without proper authorization—and this applies also to requests from the legal profession? Who backs you up when you quote your legal guide? How do you summarize your notes from staff meetings and pathological conferences? How do you handle diplomatically the physician who dictates personal letters to your clerk and then, as a return favor, lets his charts pile up? Do you attend staff meetings and in what capacity? How much material do you prepare for them? What does your department contribute to the progress of staff meetings? How do you manage the records in your small outpatient departments?

Do Machines Help?

Is your office equipped with dictating machines? Are they used by the doctors? Do they save you valuable time and are the charts properly signed when this procedure is used? Or, do you prefer personal dictation, especially with the physician who insists that signing his name in several places "just wears him out"? Have you filmed your records? Has this been successful and were they done in your hospital or shipped?

Have you a procedure book in your record department? What are some of the items that are adaptable to other hospitals? Is it your duty to see that charts are collected from the floors daily or do they pile up for several weeks?

Have you ever spoken to the nursing staff regarding medico-legal requirements in charting? What is the response? Are you given vacation relief by a trained librarian or must you work for several weeks prior to taking a vacation and then for several more after your return to get back work caught up?

Is it necessary that you pay your own expenses to institutes and conventions? Does your salary prevent you from attending these events? Do you think this is a factor in the changing of positions? What is your opinion in regard to salary and administrative support in order to keep a registered librarian encouraged and on the job?

These questions are but a few that the librarians in the small hospitals want answered.

Finally comes the "inheritance" problem, meaning that the record room usually inherits anything that can conceivably be called a record from any department wearied of its own routine records or mismanaged to the point at which a particular record becomes burdensome. Then, lo and behold, the record room, it takes care of everything! The record librarian, being used to tackling a bad job and clearing it up in a good manner, gets another added duty. The question here arises: How do you fit this into your non-departmental duties? You don't have to be irrational to work in a record room, but it helps.

We librarians in small hospitals are required to do many things that never fall to the lot of those in large institutions. For instance, we take histories. According to the best authorities this is forbidden, but I have yet to see a history on which an intelligent librarian, well educated and sincerely interested in her work, could not do a worthy job. This, to my way of thinking, is better than no history at all on the charts or one half-heartedly filled out by a disinterested physician or by one who is really too busy to sit down in the course of his day's work and to question thoroughly each patient he admits to the hospital.

A record librarian should be an asset to the staff physician in fostering his interest in good record writing. To be well acquainted with the patients, their complaints and their surgical or medical care, gives her an added advantage. When the physicals or histories are dictated, as well as the summary of the case, she may be able to point out to the physician things he has forgotten, points that should be brought up and remarked about and just plain generalized remembrance of his patient.



This, incidentally, is one of the most educational duties of the librarian in the small hospital. She acts as a moderator between the hospital, physician and the patient. But hold your hat when you ask patients their chief complaint. Often as not, it has nothing to do with their reason for admission to the hospital.

Let's Do Something About It

The record room is the heart beat of the hospital if it is utilized properly. Much of this depends on the librarian, the administration and the physician. If we are to assume the duties that are ours, and those that are thrust upon us, then I believe it is high time that the problems of the librarian in the small hospital be brought out into the daylight, recognized as to their actual existence—and that something be done about it.

Librarians even survive death and taxes. You can't drown us, it isn't legal; you can't ignore us, we are growing by leaps and bounds. Our problems should not be discussed by those who do not live with them each day, but by those who plod along with them, solving them by trial and error. We do not have interns, sometimes not even a record committee. We need to know how to approach and overcome our difficulties, not how they *might* be solved.

Librarians in small hospitals have courage, both of their convictions and of their obligations, but sometimes those who have gone ahead in our profession have already forgotten the girl just starting out. No one is ever so big that to turn back and offer a kind word, stretch out a hand, would deter her success. When one loses the touch of the common lot, she has lost the ideal of her personal life and professional attainment.

We small people not only are left behind but are forgotten.

Social Work Looks Ahead



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THIS is the realistic atomic age. Facts overtake us—too many facts, and too soon. If Dr. Chisholm's diagnosis that only larger numbers of mature, cooperative citizens can achieve peace is correct, and there's much confirming evidence, then the fostering of maturity and cooperation becomes Social Problem No. 1.

Man, at the crossroads, must choose decency or destruction. Even a professional soldier like MacArthur, aware that military machines are shortly to become obsolete, says: "The problem is now theological." To this the scientist replies: "sociological"; for only science and understanding will produce good conduct. Truly, we must behave to survive. And time is short for the salvage-preventive job ahead.

Punishment Is Ineffective

The old blaming, punishing, moralistic method is ineffective; we've suffered under it too long. Since people are only as "good" as they can afford to be, preaching at them is largely futile. Human maladjustment, a disease in which war, crime, greed, cruelty, political corruption, labor strife and other ills are rooted, will gradually respond to therapeutic social science.

This young profession, sometimes, is like a misunderstood husband. "Social work," says Bernard Shaw, "means nothing: it is a mere chapter heading. The thing to do is to advocate some specific reform and give convincing illustrations of the need for it from your personal experience, and keep at it hammer and tongs until it is effected. Abstract generalizations are useless; they are all in the Bible; but the smallest practical suggestion helps."*

The grand old man of drama doubtless honestly believes that all our troubles would end in a 100 per cent Socialistic world. Don't look now, Mr. Shaw, but your years are showing! You are right: our economic system is sick, but even if it were not, we should still have human maladjustment. A millionaire may be miserable and antisocial.

True, poverty and disease are interwoven, and we should do well to reduce both, always fortifying *prevention*. Yet, the Almighty Dollar alone does not answer all questions. A wealthy father may have a "problem" son. A matron with a fat bank account may not respond to medication because of certain ignored emotional "quirks." Examples are endless.

There is no dearth of nonfictional illustrations to refute the public's misguided yet tenacious belief that only the "poor" need social case work. Let us face it: a majority, still unaware of its urgent stake in this valuable resource, is indifferent, often hostile to it. This is descriptive, not critical. In clearer days ahead, when citizens realize that social work is their self interest and their defense, they will rally to support it adequately, as they energetically defend themselves in war. Despite the millions donated for "relief," the world's richest people's backing of its social agencies is puny and pitiful. We need more and better child guidance clinics, visiting teachers, vocational guidance, marriage counseling, recreation and other facilities.

They Won't Be the "Last Stop"

Do you consider these observations remote from hospital matters? Perhaps as alert, capable administrators you see the faint dawn of a new era, when hospitals will cease being more or less last stops on the way to the undertaker's, or patch up places, or hitting-the-high-spots-only workshops.

You may peer ahead and vision dim outlines of large, well equipped and staffed health centers of research, training and application, where prevention outranks cure; where teams of cooperative specialists integrate diagnosis and therapy, and proprie-

*Bernard Shaw's letter of 10-16-43 to Jeanne Gueydan.

tary, individualistic medical prima donnas are no more; where competition is unfashionable; where recreation, occupational therapy, bibliotherapy, psychiatry and social case work are no longer eccentric or nonessential frills; in short, where the *whole* patient is treated like a human being.

You may enjoy the prospect of intensive, effective health follow up in all patients' homes, where they participate in preventive and treatment efforts, thus earning good health, instead of expecting doctors and hospitals to hand it to them on silver platters, while they lie idle and passive. No more the stupidity and waste of expensive hospital repeaters! At least, not as many as we have now.

Integral Parts of the Community

These future medical centers will be integral parts of their communities in ways scarcely guessed now. It will not be enough to patch up bodies only—all too often just one piece of the anatomy. Emotional vitamin deficiencies also cry for attention. Always, the total living individual, with his hopes, fears, strains, prejudices, weaknesses and strengths, requires consideration. We will do more for patients, and do it *with* them, not merely as altruism but for self interest. And we will do this more intelligently. For disease and crime and dirty politics are expensive.

In years to come, health centers will find they cannot afford their present unsplendid isolation. They will respond to inevitable pressure, necessitating assumption of greater community responsibility and participation. There will be much more reciprocity between hospitals and communities, all up and down the line. No longer will hospitals nonchalantly wash their hands of patients' progress after discharge. No longer will citizens irresponsibly shrug off hospitals' shoestring finances and burdens. Hospitals and citizens will scratch each other's backs, to their mutual advantage.

Have we forgotten social work? No. We are building up to it logically and surely. For that gold mine of communal well being, so misunderstood, so grudgingly tolerated, so neglected, so feebly supported now, with rare exceptions which are not typical, will yet come into its own. This will not be merely for the pleasure and comfort of social workers, or a sop to their professional vanity. It will come because of its validity. The law of supply and demand will operate here, as elsewhere, in good time, when Americans and others become sociologically enlightened.

It is clear that in the broader sense a hospital is a social institution. As such, its social service department should have no need to apologize for its existence or be expected to be a profit making section; it should have adequate professional and secretarial staff, with good working equipment; it should rate attractive modern offices, with privacy for interviewing; it should be included in departmental and scientific conferences; it should be closely associated with other departments, especially personnel and public relations, with the administrator, trustees and, last but not least, with outside professional and civic groups.

In a nutshell: the social worker will be an important cog in the health center machinery—a humanizing, democratizing one, that will more than repay those who value this service well enough to pay a good salary for it. The social worker, no longer expected to act as errand girl, clinic secretary or administrator, medical stenographer, admitting officer, financial clerk, bill collector or nurse, will, in her own field, be recognized as the professional equal of all specialists.

She will not determine patients' ability to pay for medical attention. To do so makes her a sort of policeman, destroys rapport and nullifies her efforts as social therapist, which is her real function. Those who are concerned with matters of eligibility and payment can be given at least a little training in social work approach and philosophy, thus promoting smoother operation and better public relations.

Shall we translate these generalities into concrete incidents? Vague abstractions leave most of us cold but human episodes have appeal. You may wish to project your imagination to that fair future when a breadwinner, getting expert attention from an orthopedist for nine months after an automobile accident leg injury, will not be allowed to land in a tuberculosis specialist's office too late for cure of his chest ailment, leaving infected wife and children to mourn him.

Instead, cooperating specialists, having a complete medical-social history and genuine interest in the man before them, know of his childhood tuberculosis exposure and, hence, apply preventive measures, remembering his chest as well as his leg, and also nutrition and work and checkups of his relatives. In the coming decades, chest x-ray examinations will be routine for all patients in all hospitals. And the social worker will be considered a helpful team mate, rather than an impertinent upstart, when she gives social data for diagnostic-therapeutic group action.

Or, we may see a young matron, victim of meagerly educated, misguided parents, who, in a better age, gets more than a quick perineorrhaphy. Again, the integrating specialists, including the social worker, more effective than a solo performer interested in surgery only, go into action against Mrs. Smith's inferiority feelings resulting from protruding "rotten" teeth, adenoids and unattractive facial appearance; her insecurity about her husband's love; her extremely unbalanced diet, likely to produce pellagra; her inability to cope with the children's discipline and household problems, and various other matters.

She Still Needs Social Work

Mrs. Smith is not "poor" in money; she is a private patient. She needs social casework, although she does not know it. As things are now in many places, she will get only the perineorrhaphy; the rest of her will be ignored. Another wiser day will help her become a better wife, mother, citizen. She cannot do any of these jobs well if she is unhappy, and she is. Nor can she solve these problems on her own power alone.

Perhaps you will want to look at what happened to Mrs. Jones. The picture isn't pretty. A brilliant surgeon gave her excellent care before, during and after a cholecystectomy. A pity, though, for anything other than surgery bored him, and he was a rugged individualist in a system favoring his scheme of doing business. Mrs. Jones, left to her own devices after Dr. Cut 'Em Quick felt she had recovered from the operation, died of breast cancer after lin-

gering agonies, leaving three small children who will be less successful citizens because deprived of a wise mother's care.

No one checked on their health. Mrs. Jones's medical history was very brief and routine, only as much as the surgeon needed; there was no social history. In that happier Tomorrow we all look forward to with high hopes, those effective group clinic professionals will look Mrs. Jones and her sisters over from crown to toe and will nip malignancies in the bud. They will be looking for them bright and early. And the social worker will be right in there with them, pitching. There was much cancer in Mrs. Jones's family tree.

Social work cannot bring on the millenium suddenly. It makes no fantastic claims; it does not exaggerate present neglects and weaknesses. It challenges thinking persons who have a social conscience. It pleads for more study and real understanding and much larger, more intelligent support.

Always we must help the public understand our perplexities and needs better, for our progress is absolutely dependent on citizens' intelligent support. All of us in the health field, working together, can accomplish much if our minds are open, our hearts in the right place and our own egos healthy. With these assets, we can go forward.

How Former Patients Help Themselves

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Milwaukee

AS BETTERMENT of conditions in mental institutions is gradually coming to the attention of everyone, it should be helpful to learn of efforts which directly affect the mentally ill, namely, the forming of former patient organizations.

Our study will be restricted to two of these groups: Recovery, Inc., in Chicago, which is an active local group, and the W.A.N.A. Society with headquarters in New York, branches in several states and plans for a nationwide organization.

Dr. Low Heads "Recovery"

Both groups have been formed by former mental patients and so far each has a membership of about 200. Recovery draws its members from the private practice of Dr. Abraham Low, who has become the leader of the group not only as physician, but also with regard to the whole organization and its publications. The Recovery motto is: "No one must be held responsible for the kind of disease he contracts."

W.A.N.A.'s motto is: "We are not alone." The New York and other branches are organized by former patients with the advice of physicians and social workers. They are not exclusively directed by one person as in the case of Recovery.

Both groups aim to combat the stigma attached to mental illness and emphasize programs of self help and self care. Great potential lies in the good example which these patients set for those who are still recovering and for those on the outside who doubt that people ever can recover from mental illness. During their own crises these patients have gained insight and have learned to help themselves, which enables them to have unusual understanding and sympathy for their fellowmen who need nothing more than just this sympathy and understanding. They certainly can fulfill what Clifford Whittingham Beers used as his prime requisite when he formed the first mental hygiene society in Connecticut in 1909: "What the insane most need is a friend" (Dr. Charles W. Page).*

Recovery was formed in 1937. During the span of nearly a decade it has developed a Recovery language and technic based on certain theories of Dr. Low. From a set of three volumes of Recovery's self help system and other publications (see *Mental Hygiene,* October 1945, p. 705/6) one can learn of the meaning of "setbacks" and "sabotage," of "distressing sensations" and "allergy to tenseness" and how Dr. Low helps his patients through group therapy, panel discussions and the like.

*A Mind That Found Itself, C. W. Beers, page 395.

W.A.N.A. was founded in March 1944 and has a slightly different and perhaps even more hopeful outlook on mental illness. It emphasizes that "breakdowns no longer seem . . . unfortunate illnesses, but rather *psychological crises* through which we pass from childish dependence to mature membership in society."

Helps With Readjustment

W.A.N.A. has great potential in assisting nearly recovered patients with their readjustments in their families and communities, thereby avoiding setbacks and recommitments. Visits by former patients and their assistance to those who can soon be released are of great help and should be encouraged by administrators and social workers who are seriously concerned to help their patients.

Both groups can be proud of the numerous cases in which they have helped through their courageous and untiring efforts. The better known and the more tried their work becomes, the greater will be the benefit to others.

For the benefit of those who wish further information the addresses of the two organizations are Recovery, Inc., 185 North Wabash Avenue, Chicago 1, and W.A.N.A. Society, P. O. Box 61, Station K, New York 28.



WEATHER NOTE:

"High Winds Followed by Heavy Casualties"

Provide Experience in Disaster Work

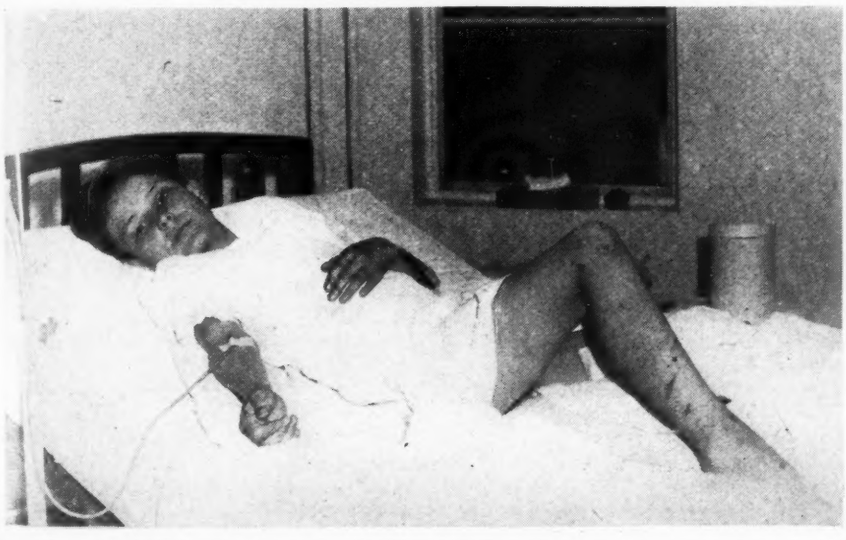
HOMER J. BARANSY
Administrator
Northwest Community Hospital
Mooreland, Okla.

NORTHWEST Community Hospital is located at Mooreland, Okla., 9 miles east of Woodward. About 8:30 p.m. on April 9, ominous winds and flashes of lightning gave some indication that quite a storm was brewing. Our first word of the disaster came when a woman brought in an injured baby. She told us that half of Woodward was blown away. We have two physicians on our staff, both of whom were in the building on the arrival of our first casualty.

I was notified by telephone and, hastily dressing, came immediately. Upon my arrival we telephoned our employes and all of them assembled, so that by 10 p.m. all employes were on duty. Extra beds were set up and a group of men scoured the town for cots, blankets and linens. Patients were placed in every available spot—hallways, treatment rooms, offices—as they arrived, and they kept right on coming all during the night and well into the following morning. Our physicians, augmented by a local dentist, gave first aid, with our nurses doing the same. Our surgical nurse autoclaved dressing material all night in preparation for the morning. Throughout the night, morphine was given those in severe pain and heavy compresses were placed on large wounds. Plasma was given to those in shock and oxygen was given nasally to cyanotic patients. Yucca and Thomas' splints were applied to fractures as temporary protection.

Little effort was made to clean the patients, all of whom were literally plastered with mud. Long distance telephone calls were placed to several nearby physicians and to our supply houses. It was necessary to place these calls through the railroad telephone system because all regular wires were out of commission.

Tetanus antitoxin and medication to combat gas gangrene were the two things we found ourselves short



Plasma and intravenous solutions were used freely to help the battered victims of the storm that blew away half the Oklahoma town of Woodward.

of and we simply requested that all available supplies be sent. During the night, six patients expired, three of them being moribund on admittance. A temporary morgue was made in a basement storeroom.

By daylight, all patients were tagged; we used shipping tags, wired to the wrist. On these tags the patient's name, if it was possible to obtain it, was written. All medications given, including tetanus antitoxin and morphine, were charted on these tags. Morning also brought us medical and nursing help. A group of doctors and nurses came by plane from Oklahoma City; others came from Clinton, Enid and Cherokee, Okla., and also from Wichita, Kan.

Sent to Oklahoma City

These people were organized into teams. One team evaluated injuries and it was decided to evacuate head injuries and compound fractures to Oklahoma City hospitals for care by specialists. This information was written on the tag. Others were slated for orthopedic care, major surgery, minor surgery or dismissal.

Notations as to parts to be examined by x-rays were also written on these tags. X-ray examinations started by noon and our portable unit was much appreciated, and very useful. The orthopedic surgeon and his team worked in an improvised cast room, his results being checked by x-ray the following day. Major surgery was performed in our regular surgery, and two minor surgical teams operated on improvised tables.

One team of nurses gave tetanus antitoxin to all patients, others were assigned to administering penicillin; 50,000 units were given all patients every three hours. Plasma was used freely and more than 100 bottles were given during the first twenty-four hours. We utilized civilians to hold plasma and intravenous solution bottles, 18 of which were being administered at one time. Whole blood was placed at our disposal by the Red Cross Blood Bank at Wichita, and transfusions were given freely. This blood was kept on hand for the first week in a special refrigerator, then the unused blood was returned in iced containers to Wichita.

The Red Cross and the state highway patrol were most helpful in bringing extra blankets, medications and oxygen. The Salvation Army placed clothing at the disposal of patients slightly injured so they might leave as soon as they had been cared for.

By 6 p.m. on April 10, all patients had been cared for and our staff was able to get a slight respite. A surgical resident from Oklahoma City stayed on duty for several days to do dressings. Routine complete blood counts were done on the third day on all storm patients. Statistically, the records are sketchy for the first twenty-four hours.

As nearly as we can estimate, our 36 bed hospital, with clinic in connection, handled the following storm patients: A total of 170 were examined; 128 were admitted as bed or cot patients; 21 were evacuated to Oklahoma City hospitals; 42 were dismissed (following first aid) during the first twenty-four hours, and 65 were hospitalized. Single rooms were made doubles, beds were set up in hallways and children were kept on cots. Only one patient died after the first twenty-four hours, and none of the evacuated skull fracture patients died. The army air forces used planes for evacuation.

In many ways we were fortunate in being able to care for so many patients so efficiently. All our regular employes have a great pride in the institution and they worked without urging until physically exhausted. Civilians in our community came freely to offer services and they were assigned work they could do. Women helped in the kitchen and laundry, cleaned and washed patients, held and comforted little children and ran errands for doctors and nurses. Men lifted patients to and from ambulances and in the x-ray department. All were imbued with a helpful spirit and were really useful.

In the light of our experience, we think we could give some advice to small hospitals in advance preparation for the emergency they might be called upon to meet. Loyal workers in every department are essential for work must be almost superhuman.

Adequate Supplies Vital

Adequate supplies are extremely necessary and in our opinion were the most important factor in caring for these people. We were able to carry on every needed service from our own supplies for almost twenty-four hours, which gave us time to renew our stocks. Plasma should be on hand in adequate amounts. Our state health department had furnished us with Red Cross surplus plasma and we were able to dispense it without stint.

A certain amount of organization is highly important, for while some waste motion is inevitable, it is imperative that one or two people be able to assign workers to useful tasks. An auxiliary light plant would be most useful, because having to work by lantern or flashlight would be quite a handicap. Fortunately, we had lights, but we plan to install an auxiliary lighting plant in our basement.

All persons who work with the sick must have times when they feel that their work is routine and unimportant. To work through a disaster and to have a part in a hard task well done is a satisfaction that makes us all glad we are helping humanity. It is this sort of thing that justifies our existence and gives us all an inward glow of happiness.

WRITE FOR YOUR VOLUME INDEX

If you bind your volumes of The MODERN HOSPITAL you will want the index to volume 68, covering issues from January through June 1947. Continued shortage of paper prevents its publication in the magazine. Write to 919 North Michigan Ave., Chicago 11, Ill.

Rehabilitation Pays—Everybody

says the Man Who Knows

EUGENE F. J. KUHN

Procurement Officer
Pennsylvania State Tuberculosis Sanatorium No. 2
Cresson, Pa.

DURING the years of World War II when hospitals were struggling to maintain their staffs and to replace the vacancies created by personnel leaving for military service, Pennsylvania State Tuberculosis Sanatorium No. 2 at Cresson, Pa., was one of the few institutions in the country that benefited from the dividends paid by rehabilitation. Many of the key positions throughout the hospital were and are filled by employes who were former patients. Having recovered their health under a supervised program of rehabilitation within the hospital, they had been encouraged to adjust themselves and prepare for possible vacancies which would occur from time to time in the various departments.

While Others Cried for Help

When we read of hospitals recruiting volunteer workers and crying for help we realized and appreciated how fortunate we were that our turnover of personnel was not above average because we had the loyalty of our workers who were on the job serving faithfully day in and out.

The type of rehabilitation with which we are familiar in hospitals is an outgrowth of occupational therapy, but with more benefits and returns to the individual, to the institution and to society. Occupational therapy has a fixed place in convalescence and is the preliminary step to rehabilitation.

It is not necessary to debate who has benefited most from such a program. From a study of the patients who have rehabilitated themselves into positions within our institution, my observation would lead me to say that the benefits were mutual, but during the recent war the institution benefited more. Personnel changes were fewer, those holding key positions had had years of experience and knew the background of the sanatorium and the patients' attitudes. There was a loyal cooperative spirit, with all striving toward one end: the comfort and welfare of the patient.

Conditions could have been worse. We did have to close a few wards because of a shortage of nurses and doctors, but it was those who carried on the routine work who made the machinery click and kept the institution operating surprisingly smoothly in spite of rations, priorities and restrictions.

One may learn in more detail the benefits to our hospital from the following histories, but before any one individual case is related, it should be observed that first of all the hospital is a tuberculosis sanatorium owned and operated by the Pennsylvania Department of Health. It is the object of the state health department to rehabilitate every patient who comes to the sanatorium for treatment, his physical condition permitting, so that he can if possible proceed to lead a normal life and eventually be able to earn his living.

Out of the steady stream of patients who enter the restricted life in a sanatorium, a number by choice and circumstances become the future employes and officers of the institution. For example, classes have been conducted for selected men and women patients who desire to specialize in tuberculosis nursing, particularly in sanatoriums.

In addition to a long close apprenticeship supervised by registered nurses, the curriculum includes: lectures in principles of practical nursing, personal and institutional hygiene, anatomy and physiology; laboratory demonstrations of work in tuberculosis bacteriology and urinalysis; observation of pneumothorax clinics; surgical nursing of the tuberculous; lessons in ethics and elementary materia medica; detailed teaching of diets in tuberculosis, and, in general, all the routine care of the tuberculous patient, including medical and surgical special care.

Graduates of these classes have become loyal workers and nurses, sympathetic with the desires and mental attitudes of the patient. They maintain a highly personal interest in the patient because they, too, have "taken the cure," and they appreciate with a sympathetic understanding the days of separation between the patient and his family which stretch into months and years.

Nurse Learns Pharmacy

A few more examples might be cited of special rehabilitation. A graduate nurse from these classes learned to do exacting work in the pharmacy. Under the guidance of the medical director she did so well that she was eventually placed in charge of the pharmaceuticals required by the staff physicians and all drugs stored at the nursing stations. I doubt whether we could get anyone to take her place who would be as loyal or as efficient and do the work better.

A young man was permitted to venture on exercise in the x-ray laboratory. In the evenings and during his spare time he was trained by the chief of the medical staff to do considerable x-ray work. An opportunity was given him to finish his high school credits so that he could prepare to take the examinations required by the Society of Registered X-Ray Technicians. This young man

was finally put in complete charge of our x-ray department as a registered technician.

Rehabilitation has enabled him to be self supporting, to do pleasant work, to get married and raise a family. Last of all, he has found a place in society and become a part of the community. The sanatorium has benefited from the services of a grateful young man who does excellent x-ray work and fills an important job in the routine life of the institution.

Our sanatorium clinical laboratories are under the complete charge of a young woman and man who were given initial training in the institution and granted an opportunity to fit themselves, and also their three assistants, to do all the laboratory procedures for an 850 bed sanatorium.

The Hospital Has Benefited

Has the institution benefited? It Has with capital letters. We have filled the x-ray department, the laboratory and pharmacy, the orderlies' section, the procurement division, accounting and pay roll staff, the maintenance department, shoe repair shop, post office, teaching staff for the children of the sanatorium school, clinical stenographers and clerks for the administration office and many nursing responsibilities with former patients who were given the opportunity to fit themselves to earn a livelihood. Not to be overlooked is our popular community store and gift shop which is managed and operated by rehabilitated patients for the benefit of the in-patients.

Many of our patients have taken advantage of the rehabilitation program of the state department of education as they leave the sanatorium. These patients, on special grants, have taken courses in watch repairing, photography, mechanical drawing, typewriting and stenography, secretarial training, bookkeeping and x-ray work. Reports from them reveal that they are all earning their own living. A few are supporting families and have become prominent citizens in their communities.

It has been remarked by Dr. H. A. Pattison of the Potts Memorial Hospital, an authority on rehabilitation, that the surface of rehabilitation has only been scratched. Hospitals in general may well investigate the possibilities of rehabilitation as our experience shows that those of our employes who have come to us through the rehabilitation route are more loyal and contented and the turnover among them is less. We, therefore, have reason to say that rehabilitation has paid us handsome dividends.

Narcotic Control—Fact or Fancy?

SARAH HOOKER HARDWICKE, M.D.

Assistant Director
Strong Memorial Hospital
Rochester, N. Y.

IS THE narcotic control system in hospitals really adequate, or are hospitals being lulled into a false security? Are surface requirements of state and federal authorities being met while hidden loopholes are overlooked?

Some months past one hospital was startled out of its complacency by the discovery that on one of its floors a morphine sulfate tablet count revealed two more tablets than could be accounted for. This led to chemical testing of the tablets in the vial and the further discovery that several of them were not morphine. Other narcotics on the floor had been tampered with, yet to the naked eye all of the hypodermic tablets in the vials looked like the narcotic they were supposed to be. Several days of arduous checking and investigation resulted in the apprehension of the offender, a private duty nurse who, by that time, had left to work in another unsuspecting institution in the city.

Investigation of the background of this narcotic violation led to some startling facts. First, the individual was known as a drug addict to the nurses' registry through which she came to the hospital, yet the registry "protected" her by withholding this information. Second, there were being used narcotic tablets of different strengths and substances which resembled each other and other drug tablets so closely that a chemical test was necessary to establish the identity of each beyond question. This was true of both mouth and hypodermic tablets.

Narcotic counts might check, but patients were exposed to the possibility of either failing to receive the relief of pain they desperately needed or receiving a substance that might actually do them harm. It might be said also that other members of the personnel inadvertently were exposed to temptation.

Inquiries have been made to manufacturers of narcotic preparations to suggest the possibility of distinctive colors and shapes for various drugs and strengths of drugs. The use of narcotic solutions, distinctively colored, as a trial replacement for tablets is being tried. The use of such solutions for narcotics has recently been recommended by several groups as a time saver for nursing personnel. It has not only this advantage but also that of better approach to asepsis. How sterile are tablets which have been rolled about on paper or with fingers in a daily narcotic count?

Take All Precautions

Needless to say, the old precautions of locked boxes on nursing floors, of allowing access to one responsible nurse only for each duty period, of keeping careful stock control, of safeguarding narcotics in transit at time of refill are just as important as ever.

It is believed that to these should be added chemical testing of floor supplies at irregular intervals and without warning. It is also suggested that information, when known to referring agencies concerning previous addiction of nurses and other hospital personnel, should be transmitted to responsible hospital authorities for protection of the employes and patients alike.

It is believed that the use of distinctively shaped and colored tablets, or colored solutions, would act as a deterrent to the unstable former addict and would help to make fancied control of hospital narcotics more of a fact.

New World A-Coming for Psychiatric Patients

SAMUEL J. LIPNITZKY, M.D.
Dixon, Ill.

A NUMBER of issues are involved in the complicated subject of hospital treatment of psychiatric patients. However, this article will be limited to three general considerations: (1) new kinds of psychiatric hospitals; (2) the definite grouping of the psychiatric patients who receive hospital treatment, and (3) the organizational approach and methods of actual management of the proposed psychiatric hospital system.

Not all psychiatric patients need hospitalization and many of those who do certainly need not stay in a hospital permanently. Hospitalization of the mentally ill is justified only when the patients benefit from, need and receive hospital treatment. Even though one accepts the thought that a psychiatric condition is different from other medical conditions, how can anyone explain or excuse the prevailing custom of letting nonmedical men, a judge and jury, decide upon commitment of a person to a psychiatric hospital for care and treatment? Are not diagnosis and treatment of disease the job of a doctor and nobody else?

Patients Must Be Sorted Out

In his handling of the sick, the physician is always confronted with an immediate problem of sorting the patients as to the type of illness, *i.e.* acute, subacute and chronic. Some of them he can treat in their own homes or in his office; others, he will attend to at various clinics, while many will have to be sent to a hospital where, after a shorter or longer period of time, they will improve, recover and be ready to go back home.

Most of our nonpsychiatric hospitals are prepared to serve the physician and the patient so that the best results are obtained from hospitalization. Depending on the probable length of the illness and its nature in general, we have provided the nonpsychiatric patient with emergency, general, communicable, orthopedic and other hospitals and also with institutions and sanatoriums for the chronically ill.

Strangely enough, it is altogether a different story with the hospital treatment and care of psychiatric patients. Recuperating, acutely ill and chronically ill mental patients are kept together on the same grounds, frequently in the same building and even in the same dormitory. Except for the bedridden, disturbed or otherwise incapacitated patients, they usually eat in the same dining room, attend the same "social" affairs and are assigned to work in the many different industries of the institution. The assignment to a particular job is not always based on therapeutic consideration, but rather on the necessity to keep the wheels of the hospital economy running.

The plan outlined here recommends a special system of hospital care for the mentally ill. The inauguration of this system should bring improvement and remove the "sore spots" from today's hospital treatment of psychiatric patients. It is based upon the following considerations:

1. A psychiatric hospital is a place for those who require special psychiatric treatment as indicated and prescribed by a qualified physician.

2. Psychiatric patients should be treated at such hospitals until they improve, recover or are helped to an extent that further hospitalization is of no real benefit to them.

3. Custodial care for aged, harmless, poor and other patients who crowd our mental institutions under the guise of "psychiatric cases" is not a function of a psychiatric hospital.

4. With all the available new knowledge and means at the doctor's disposal of how to treat the mentally disordered, our society cannot be satisfied with the outmoded and, in most instances, inappropriate and careless management of a great majority of psychiatric patients.

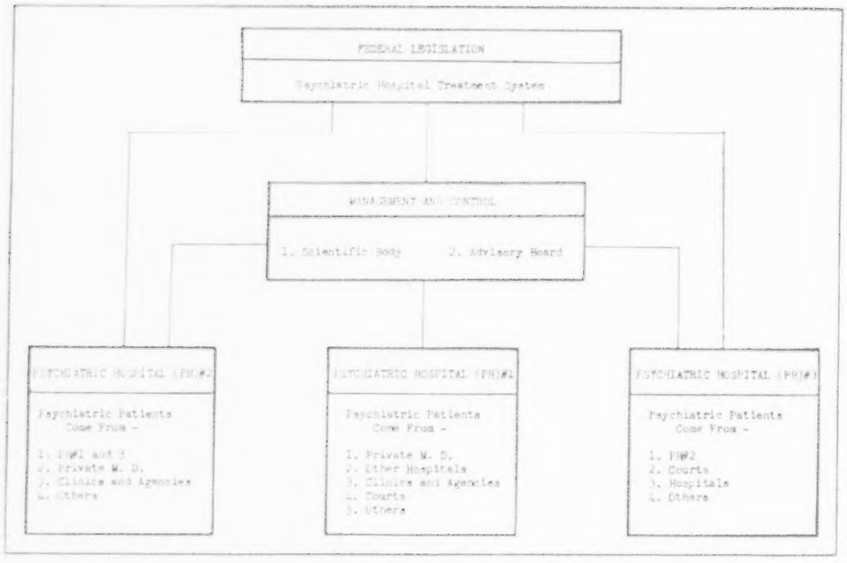
5. Hospitalization is not always the single or proper treatment of the mentally ill; nevertheless, for those who require it, the finest should be offered and psychiatric hospital care should compare well with that given in any modern general hospital.

Right Approach Is Essential

6. Because a psychiatric patient is afflicted more or less with a dysfunction or actual disorganization of his total personality and because it is important to prevent a faulty start in the therapeutic approach, an approximate estimate of the length of hospitalization required in each case is vital before the patient enters the hospital. His doctor must have a definite opinion as to whether the patient really needs hospitalization. Can he treat the patient at home or at the office? Is this illness of an emergency, convalescent or chronic character?

7. Statistically, it is well established that the large majority of psychiatric patients who are improved, recovered or otherwise benefited by hospitalization are discharged

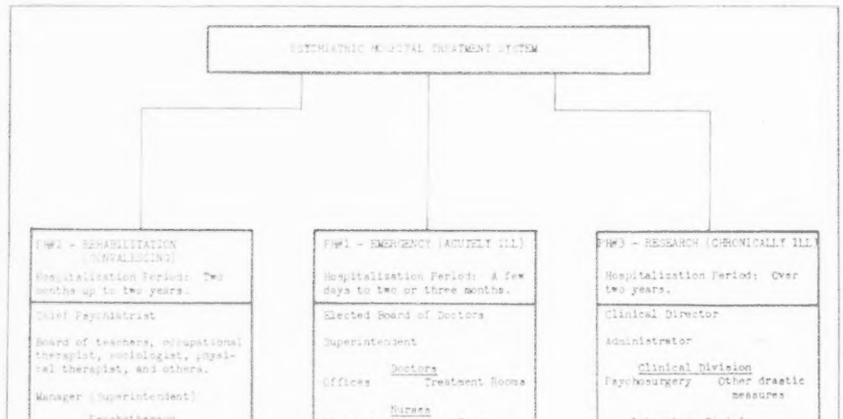
DIAGRAM A—THE PLAN AS A WHOLE



recovered and who are in need of rehabilitation and readjustment. A quiet site with attractive grounds, away from the tumult of the big city, is the most desirable location for this type of hospital.

The last in the chain of the proposed system of psychiatric hospitals is P. H. 3. To this hospital chronically ill patients are admitted. Their illness has lasted for more than two or three years. They are the socially "leveled off" psychotics, the deteriorated or stationary cases of mental disorder for whom there is little hope of recovery or further improvement. The hospital treatment at P. H. 3 is mainly in the nature of clinical investigation and scientific research undertaken to alleviate suffering and to rehabili-

DIAGRAM B—P. H. 1, 2 AND 3



from a hospital within the first two years, many of them within a few months or even a few weeks after admission. Would it not seem advisable to group the psychiatric patients in accordance with the estimated length of stay in the hospital?

8. When a mentally ill patient is sent to a psychiatric hospital, his physician should have gathered all important information about the psychiatric condition, the indications for hospitalization and the treatment of the existing symptoms, as he would have done in any nonpsychiatric illness. Thus, time customarily spent by the hospital physician for study and presentation of the case to a staff for diagnosis and treatment is not wasted, but saved.

It will not be necessary to lump together, because of "certification and commitment," an acutely hallucinating young woman, a demented senile individual and a middle-aged chronic alcoholic. By knowing beforehand the approximate length of time the patient may need for his treatment in a psychiatric hospital, it should not be too difficult to designate each psychiatric case as acute (emergency), subacute (rehabilitation) and chronic (research). (See diagrams A, B and C.)

On the basis of these facts, a plan for hospital treatment of mental patients is visualized as being a system of three sets of psychiatric hospitals, *i.e.* P. H. 1, P. H. 2 and P. H. 3, to which patients are directly admitted in accordance with their needs.

P. H. 1 is comparable to other medical hospitals that render care to patients in an emergency or during the acute phase of their illness. A large turnover of admissions and discharges can be expected. Preferably, this hospital should be located in a city which serves as a center for the population of several counties and is within an easy reach of the patients, their relatives and doctors.

P. H. 2, on the other hand, is a hospital for patients whose preestimated period of psychiatric disability may range from a couple of months up to two years or so. They include the gradually improving, recuperating and, in general, convalescing patients who are past the crisis of their acute illness but not yet fully

tate the patient. The investigative, research importance of P. H. 3 makes it advisable for this hospital to be located near a university and probably in a suburban area.

As has already been mentioned, P. H. 1 is essentially an emergency hospital for the acutely ill. Wards are provided for men, women and children, with all of the necessary segregation deemed beneficial for all concerned. The population of this hospital consists of persons referred for treatment by their private physicians, by doctors from other hospitals, by accredited mental hygiene clinics and by the police or court psychiatrists. The possibility of nonpsychiatric acute complications which often accompany the mental condition is not forgotten.

Twenty-five per cent or more of the hospital medical staff are specialists in many other fields and not in psychiatry alone. An elected board of doctors is responsible for all medical and scientific arrangements. A superintendent and his assistants attend to the necessary daily business of running a hospital. The resident staff of medical interns is augmented with a few men and women whose training in psychology, psychometry, sociology, theology and other studies requires the experience that can be gained by service in a psychiatric institution.

No lengthy procedures for collecting social data and for classification and study of each patient are of much significance for the treatment of the psychiatrically ill at P. H. 1; theirs is an acute illness and should be treated as such.

The doctor's office at this hospital is modern and equipped with the most up to date apparatus. One patient at a time is interviewed and his statements, behavior and voice are recorded for future reference by means of a movie camera and sound recorder. Only the most necessary examinations are made on admission and then for the sole purpose of deciding what symptomatic or other therapy is indicated. The physician who sends in the patient to the hospital supplies his diagnosis, which an emergency consulting staff at P. H. 1 confirms.

The patient has to be helped and relieved, the sooner the better. Treatment rooms are many in kind and provide for shock therapy, fever therapy, hydrotherapy and for other recognized forms of treatment. It appears that treatment with special diets has a significant value in the care of the mentally ill and the use of such diets is encouraged. Television enables the nurse in a special observation room to watch every movement of her patients on the wards. At any time she can look at a screen in front of her and see how the patients are getting along.

Attendants and guards employed in present day mental hospitals have no place in P. H. 1, P. H. 2 and P. H. 3. Trained nurses have experienced little difficulty in taking care of disturbed, impulsive and even combative patients in nonpsychiatric hospitals. Why should they experience it in a psychiatric hospital?

A mentally ill person does not require a police car or a strait jacket while he is being transported to a psychiatric hospital either. The private doctor on the outside can see to it that his patients are reasonably peaceful and their excitement is allayed when they arrive at P. H. 1 for treatment. Incidentally, the use of unbreakable transparent plastic material should do away with bars on the windows and with locked doors of the rooms in which "dangerous" patients are confined.

Finally, the laboratory of P. H. 1 is provided with technicians and instruments to conduct the required hospital work and to assist the doctors in their diagnoses and treatments. An electroencephalographic machine, amplifying apparatus for detecting variations in sounds inside the skull and all other new devices of benefit and value to the patient are standard equipment of this laboratory.

A certain number of psychiatric patients will fail to recover completely under the P. H. 1 treatment. They may need social retraining and special education for better readjustment before returning to their homes. For these patients a special program of treatment and reeducation, encompassing a period of one year or longer, might become necessary.

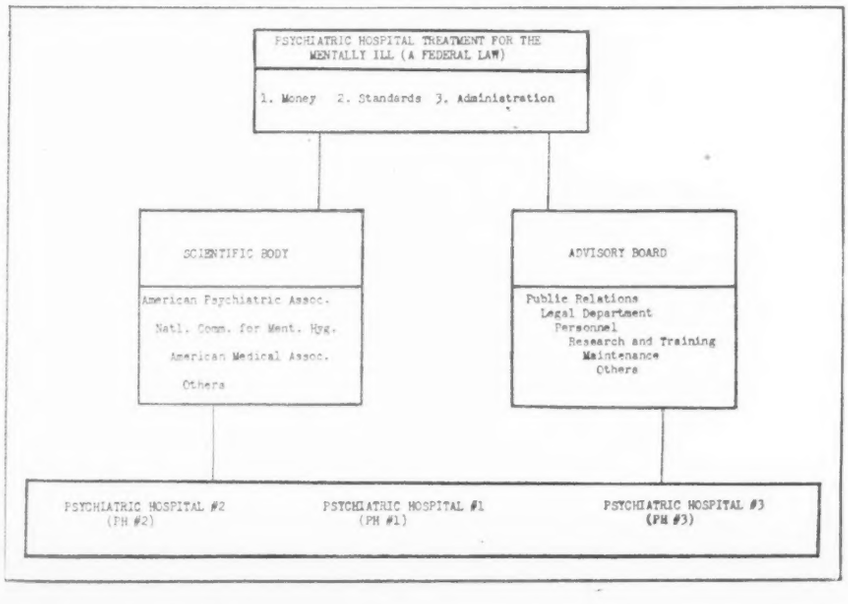
They are the ones who are transferred to P. H. 2, a rehabilitation treatment hospital. Some of the patients from P. H. 3 who have shown improvement may also be ready for treatment at P. H. 2 and they form another small group of admissions. Private practitioners, other hospitals and agencies contribute their share of new or readmitted patients.

In charge of P. H. 2 is a chief psychiatrist, a director who, with the other psychiatrists, prescribes and outlines a plan of treatment, retraining and rehabilitation for the patients. A board consisting of teachers, recreational and occupational therapists, artists, musicians, sociologists, physical therapists and lecturers assists the doctors in coordinating psychotherapeutic work with theirs and scheduling a daily, hour by hour special program for each individual or for groups of patients.

Insofar as possible a home-like social environment is established. In general, though, an atmosphere of school life with its regulated activities prevails at P. H. 2. As in the case of P. H. 1, a manager or superintendent takes care of the purely administrative and business side of the hospital.

With a somewhat extended hospital stay, protracted courses of psychotherapy, as, for example, psychoanalysis, are made possible. Group treatment, psychodrama with television and other modern methods are utilized. All the therapies are to be blended in a graded sequence, carefully scheduled and yet sufficiently flexible to help each patient make the necessary adjustment. Sexes

DIAGRAM C—MANAGEMENT AND CONTROL OF P. H. 1, 2 AND 3 SYSTEM



and ages are not segregated, socially at least, any more than they would be in actual daily life outside the hospital. Here, too, professional nursing helps the interns and resident doctors dispense with the services of the traditional "state hospital" attendant.

The patients in P. H. 3 include the chronically ill who cannot go back home after having been treated at P. H. 2; patients sent in from courts and other hospitals, and all those who require the particular type of care offered here.

A clinical director who is a well qualified neuropsychiatrist with much experience in general medicine and surgery and has definite inclinations toward research is the head of this hospital. The medical men and others working under him must have also shown a real interest in investigative work concerning treatment and study of psychiatric conditions.

To accomplish its purposes, P. H. 3 has two interrelated divisions—one of clinical application, the other of purely laboratory approach. Psychosurgery and other drastic forms of therapy bring the psychiatric patient closer to recovery, while psychobacteriology, psychopathology, biochemistry and other lines of research aid the discovery of the involved, underlying causes and effects of mental ill health.

The chronically ill at P. H. 3 are supplied with infirmary and general hospital care facilities because of the prolonged period of hospitalization. Yet no harmless psychotic, chronic alcoholic or any other person whose problem is chiefly that of family and community burden, and is not medical from the standpoint of needing psychiatric treatment, is acceptable at P. H. 3.

At P. H. 3 the patients are not leading a vegetative existence only. Their environment is, of course, protective, but at the same time everything is attempted in order to introduce stimulating influences in it. Instead of standing in a corner or remaining in a rocking chair all day long, the patient observes a regulated schedule of exercises and work assignments. If necessary, in addition to useful industries and occupations, "useless" industries and occupations are created so that the patient is kept busy. From such a beginning, projects of more constructive and reeducational value are gradually introduced.

How can such a plan become practicable and workable? Well, let us look at Diagram C. There, in general terms, is the explanation.

Each state or community would contribute money to the program of its psychiatric hospital system. A federal law would ensure the maintenance of a high standard of care by states and local communities. Under the protection of this national legislation the actual management and control over the system would be entrusted to a strictly scientific body made up of elected members from the representative national medical organizations. The American Psychiatric Association, the National Committee for Mental Hygiene and the American Medical Association would play important rôles and other scientific and interested groups would be welcome to participate.

An advisory board of experts—architects, economists, engineers, scientists, medical men, statisticians and many others—would interpret the policies determined by the scientific body. This advisory board would organize departments or divisions of public and legal relations, of research and training, maintenance and personnel. The national structure of such an advisory board would set an example for similar boards in each state. The latter boards would supervise the hospital treatment system and the individual hospitals through the immediate authority of the doctors, chief psychiatrists, clinical directors, superintendents and their assistants.

What the Plan Might Bring

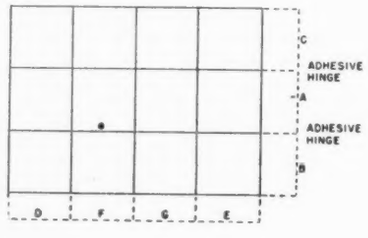
Let me point out a few improvements in the hospital treatment of psychiatric patients that the proposed plan might bring.

1. Mismanagement of all kinds can be avoided to a great extent.
2. New goals can be achieved more easily when the welfare of the psychiatric patients is in the hands of doctors and others whose sole aim is to benefit the mentally disordered.
3. The overcrowding of the psychiatric hospitals can be much relieved by the adoption of the system and the recognition of the fact that large numbers of the chronically ill do not require hospitalization for psychiatric treatment.
4. Psychiatric patients can obtain better care and treatment when they are not grouped together, when each phase of their illness is evaluated carefully and separately, when the psychiatrists and other personnel are well trained and are paid good salaries and when the specter of the state hospital attendant disappears from the scene forever.

For Folding Surgical Sponges

THE folding of surgical sponges is a major chore in many hospitals, often requiring the use of trained personnel. An easily made device expedites this procedure and the resulting sponges are neat and uniform. Sgt. James T. Brandon, Station Hospital, Fort Oglethorpe, Ga., reports that the only materials required to make the device are heavy cardboard and 2 inch adhesive tape.

Twelve cardboard squares, each 4 by 4 inches, are hinged together by adhesive tape as indicated in the accompanying sketch. In using the folder, the gauze is placed on the cardboard. Panel B is then folded on



panel A, then returned to the original position, thus producing the first fold in the sponge. Similarly, panel C is folded on panel A, then reopened. Then panel D is folded over, then panel E and finally panel F. The same principle may be utilized in preparing folders for other sponge sizes by changing the size of the cardboard squares used.

Reprinted from the Bulletin of the U. S. Army Medical Department.

THE FUNCTIONAL BASIS OF HOSPITAL PLANNING

CONTINUING A STUDY BY THE DIVISION OF HOSPITAL FACILITIES

UNITED STATES PUBLIC HEALTH SERVICE



ADJUNCT DIAGNOSTIC AND TREATMENT FACILITIES

LABORATORY

IN THE SMALL HOSPITAL of 50 beds or less, one room for all laboratory activities will suffice. In larger hospitals it is usually necessary to assign separate areas for pathology, serology, bacteriology, chemistry, hematology, urinalysis, blood bank or other special services.

In larger hospitals, an office for the pathologist and perhaps a secretary is indicated. A small waiting room as well as a small room for taking specimens should be provided for patients coming to the laboratory. The latter room might also serve as a bleeding room if the hospital contemplates installing a blood bank. It is advisable to consult the pathologist as to rooms required and their design, especially for the larger hospitals.

The laboratory should be on a lower floor and so located as to be accessible to members of the medical staff and to outpatients who may be sent to the laboratory for specific procedures. Ample birch or maple top tables impregnated with acidproof finish, cold and hot water taps, compressed air, vacuum, gas and electric outlets and acidproof laboratory sinks with gooseneck spouts should be provided.

Rubber floor covering and acid-resisting asphalt tile are more resistant to acids than is linoleum.

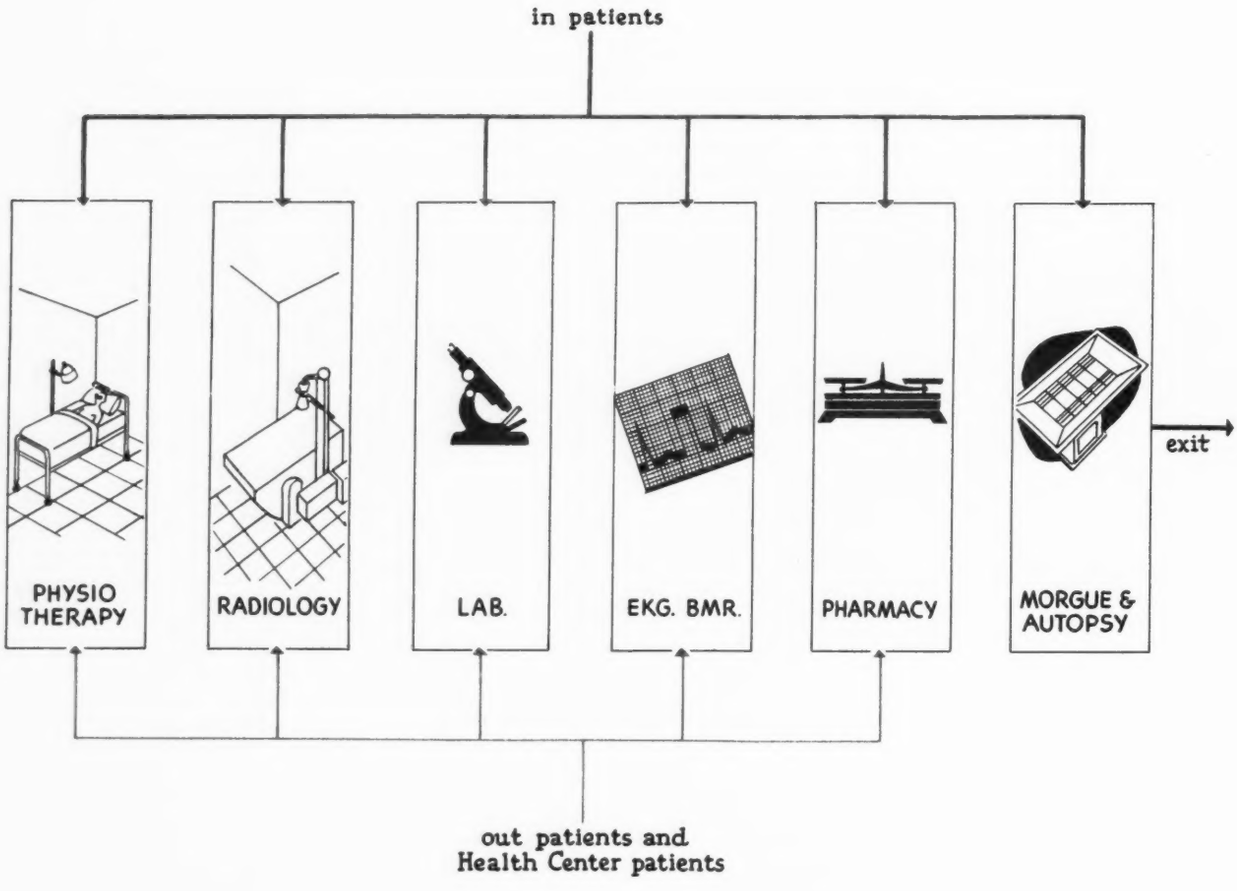
Acid-resisting piping should be considered for waste lines. Special glassware washing facilities and wall peg-boards should be supplied. A standard mechanically ventilated chemical hood, autoclave, hot air sterilizer, incubator, fire extinguisher, sweep-second hand clock, house telephone and a bulletin board should be installed. One refrigerator for reagents and one for the blood bank have proved to be more satisfactory than a single large unit. Distilled water is supplied by the central sterilizing facilities.

Small laboratories may be indicated on each nursing floor for the convenience of interns.

If a frozen-section laboratory is not provided in the operating room suite, space for the storage of a mobile truck with freezing microtome, a shelf for microscope and staining materials may be provided in the laboratory.

Sufficient closet and cabinet space for supplies is essential. Facilities for exhibiting specimens are often desirable for teaching purposes.

Separate animal quarters, preferably located in another building not too far distant, may be required in larger hospitals. If these are installed special provi-



sions for feeding and sanitation must be provided as outlined by the pathologist.

MORGUE

THE MORGUE AND AUTOPSY ROOM should be arranged so as to prevent unnecessary contact of the public and unauthorized personnel with morgue procedures. It should be convenient to the elevator, with an isolated exit, if possible, to the service yard for the use of undertakers. Adequate ventilation is necessary.

The room should be equipped with a floor drain, combination instrument and scrub sink and hot and cold water supply by knee or foot action valve. Water supply at or above the autopsy table is required and vacuum outlet is desirable. Space will be required for a built-in instrument case, instrument sterilizer, work table and autopsy table. Shelves should be provided for specimens. The floor should be of water resistant material, preferably tile, and the walls should be tiled to a height of 5 feet 6 inches. Adjacent shower and dressing facilities for use of the pathologist are required.

A refrigerated compartment for bodies, containing from one to six crypts, depending on the size of the hospital and local undertaking practices, will be needed. These crypts may be cooled with individual refrigeration units or from the central refrigerating system. If sufficient space is available, a mortician's workroom may be desirable.

RADIOLOGY

THE DEPARTMENT OF RADIOLOGY should be so located as conveniently to be accessible to the inpatient areas, as close as possible to the emergency room and to the outpatient clinics if these are in the hospital. The location should be such as to permit adequate natural ventilation and freedom from dampness.

Detailed requirements of the department should be governed by the advice of the radiologist inasmuch as these requirements may vary widely, depending on the types of services contemplated.

In the small hospital, minimal provisions will include a space of not less than 200 square feet for the radiography and fluoroscopy room, with provisions for complete darkening; a control booth; a darkroom; special film storage space conforming to the requirements of the National Board of Fire Underwriters, a dressing room connecting with both waiting area and treatment rooms; a lavatory and toilet; space for desk, files and viewing boxes, and storage



Flow chart showing various adjunct diagnostic and treatment facilities.

space for portable or mobile equipment and supplies. House telephones, electric clock, recessed fire extinguisher and bulletin board will be needed.

In larger hospitals this department may be extended to include a separate radiographic room or rooms, fluoroscopic room, therapy room, viewing room, office, waiting room. A special electrical current source for radiology should be arranged with separate power line and transformer to prevent current fluctuation; provisions should be made for adequate grounding. Installation of the radiologic unit should permit access to the machine, preferably from both sides, by a bed or stretcher.

DARKROOM. The darkroom has a minimum of 75 square feet, is lightproof, mechanically ventilated and equipped with developing tank, film storage box, work counter, sink, film dryer, built-in view boxes, red and white lamps, self closing and fire resistant waste receptacle. If possible, a refrigerated water supply and thermostatic mixing valves should be provided for the developing tank. Adequate lead or other acceptable x-ray protection must be installed where indicated. View boxes are much more satisfactory if recessed into the wall and are usually required in pairs.

The darkroom should be so located that lightproof pass boxes may be installed to radiographic rooms. In larger hospitals a small darkroom may be provided in the operating suite areas.

BASAL METABOLISM, ELECTROCARDIOGRAPHY

ONE ROOM WILL USUALLY serve this dual purpose and must be in a quiet location.

Except for equipment required in the tests, it will be similar to a one bed room. Since these tests (and observations) are usually done by, or under the general supervision of, the laboratory technician or director, reasonably convenient access to the laboratory is preferred.

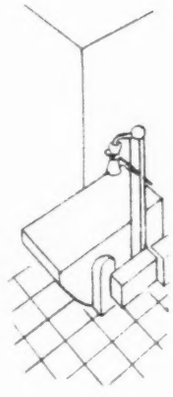
Draw curtains, or other methods of darkening the room, will be necessary; separation by a cubicle curtain to eliminate possible distraction of the patient is advisable. Acoustical treatment of the ceiling is preferred. Convenient handwashing facilities and a supply closet or cabinet should be available. Ordinary electrical outlets, conveniently placed, will suffice.

Developing of the electrocardiographic film may be accomplished in the x-ray darkroom.

PHYSICAL THERAPY

EVEN THE SMALLEST GENERAL HOSPITAL will have considerable physical therapy and the trend is toward increasing this form of treatment and concentrating required facilities. This permits more extensive use and greater efficiency under trained supervision in caring for both inpatients and outpatients.

The principal divisions of the department are for electrotherapy, hydrotherapy and exercise. The first is by far the most extensive in the average hospital and in the small unit may constitute practically the entire activity. Short-wave diathermy, infra-red and ultraviolet equipment is essential.



Areas in Sq. Ft.	50-Bed	100-Bed	150-Bed	200-Bed
ADJUNCT DIAGNOSTIC AND TREATMENT FACILITIES				
PATHOLOGY				
Laboratory	280	455	620	745
BMR, EKG. & Specimen Room	—	190	190	207
Office	—	—	135	170
Morgue	280	495	495	495
Total	**560**	**1,140**	**1,440**	**1,617**
RADIOLOGY	565	565	1,080	1,285
X-RAY THERAPY	—	—	—	1,775
PHYSICAL THERAPY	520	820	1,020	1,215
OCCUPATIONAL THERAPY	—	—	400	495
PHARMACY *(bulk stores included in central stores area)*				
Solution	—	155	155	170
Pharmacy	205	255	255	280
Manufacturing	—	—	190	280
Total	**205**	**410**	**600**	**730**
Grand Total	**1,850**	**2,935**	**4,540**	**7,117**

Hydrotherapy is better separated from the electrotherapy area. Facilities here vary from small mobile tanks to elaborate installations of swimming pools, Hubbard or other tanks, showers and continuous flow and sitz baths. Tanks and wringer for hot and cold compress applications, and fixed or mobile arm and leg baths may be desired.

The exercise area, if furnished, requires bars, posture mirrors, steps, ladders of various types, pulleys, walkers or other similar equipment determined by the extent of the department.

Storage space for apparatus is required.

In the larger units, an office, waiting space and a toilet are necessary.

OCCUPATIONAL THERAPY

FACILITIES FOR OCCUPATIONAL THERAPY are usually not so extensive in general hospitals as are required for tuberculosis, mental disease, convalescent and chronic disease institutions. However, when installed, a separate room is necessary. Equipment for ordinary activities here includes stainless sink with drainboard, benches for leather, metal and carpentry work, saws, grinders and lathes. Considerable shelving and storage cabinets for materials are required.

PHARMACY

THE AREA SUGGESTED for the activities of the pharmacy does not include space for bulk storage of pharmaceutical supplies, this being provided for in the area allotted to general stores.

In the small hospital, nothing more than a dispensing pharmacy will be required. It should be convenient to the outpatient department, if any, and accessible to the elevators for service to the various nursing stations. Equipment includes proper shelving, drawers, work tables with gas and electrical outlets, drug cabinets, acidproof sink with drainboard and drain rack and locked alcohol storage space. A house telephone and bulletin board are needed.

Space will be required for a refrigerator and a safe for narcotics. The prescription section should conform to the equipment specifications of the National Association of Boards of Pharmacy and the American Pharmaceutical Association. Sectional cabinets manufactured specifically for pharmacists' use and to fit any area can be purchased. A dispensing window provides the only access for the public. If the hospital is extremely small and has little or no outpatient department, a dispensing pharmacy may not be required; a drug room will be sufficient.

SOLUTION ROOM. In hospitals of 100 or more beds, a separate area for the preparation of solutions is considered desirable.

The solution room should be equipped with distilling apparatus; a work counter with gas, vacuum, air and electrical outlets; storage cabinets; shelves; a sink with drainboard and drain rack; pressure sterilizer. The solution sterilization may be done in the central sterilization and supply section but preferably should be done in the solution room.

If processing of blood plasma is contemplated, consideration should be given to combining the processing laboratory with the solution room.

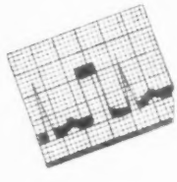
MANUFACTURING. Determination of the extent to which manufacturing will be done in larger hospitals is a question of policy, and the extent to which provisions for this activity are furnished will be subject to the decision of the governing agency of the hospital.

Space is assigned for manufacturing, including the preparation of large quantities of solutions, such as mouth washes, rubbing alcohol and liquid soap, and for facilities, such as ointment mills, tablet machines, equipment for filling collapsible tubes and ampules, extracting and filtering. A water resistant floor with drain, adequate shelving and work space are required in this area.

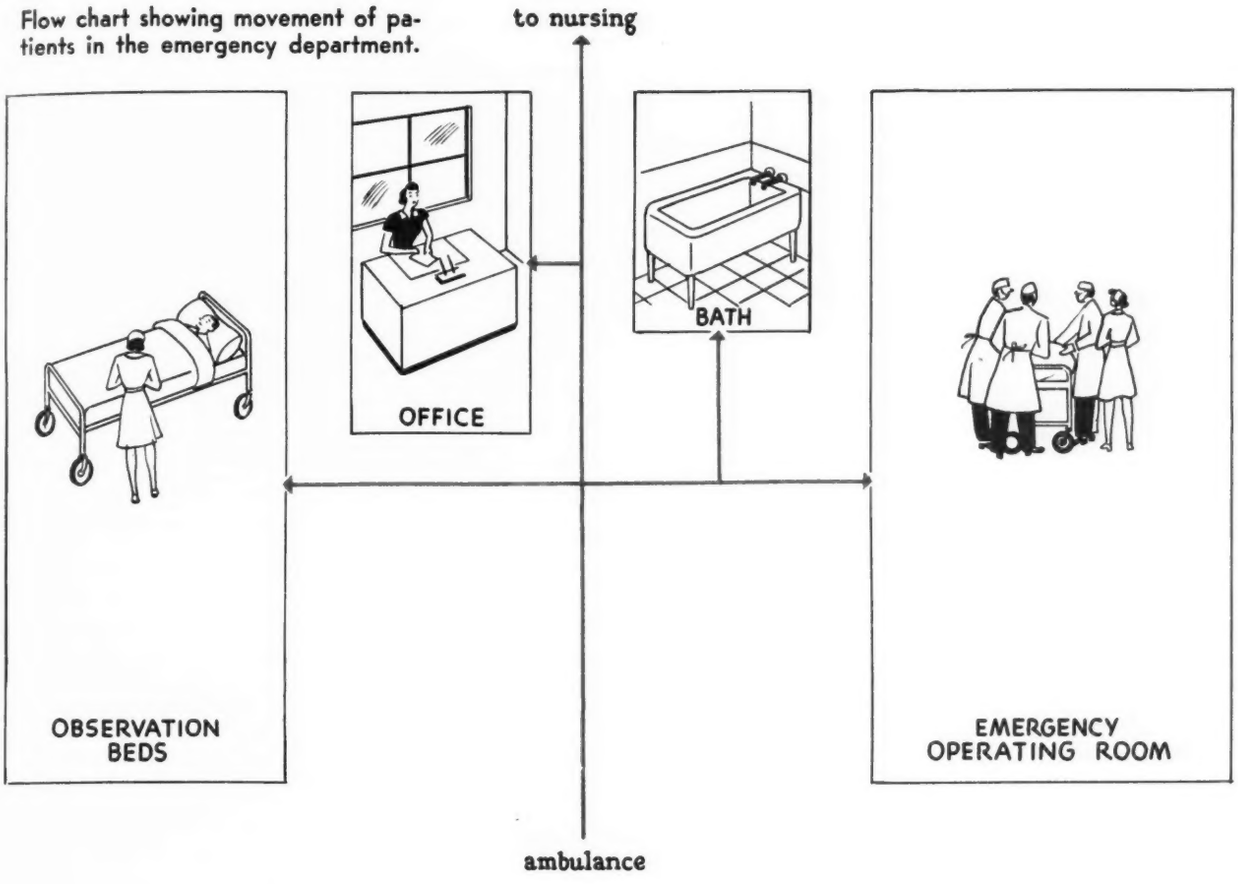
The manufacturing room may be located in the basement, directly under the pharmacy. A dumbwaiter should connect it to the pharmacy and there should be means of direct access to the pharmacy and to the bulk pharmacy stores.

In the smaller hospital, where only one pharmacist is on duty, often without assistance, it is preferable that the manufacturing room be adjacent to the pharmacy to obtain more efficient utilization of that employe's time.









Flow chart showing movement of patients in the emergency department.

EMERGENCY DEPARTMENT

THE EMERGENCY DEPARTMENT SHOULD be so located that patients arriving by ambulance may have direct access to the emergency room. For this reason this department is usually located on the ground floor in the rear of the hospital building. It should not be directly connected to the operating suite nor should the emergency room be counted as an operating room. The emergency entrance should have a convenient loading platform or a ramp and a marquee to protect patients being taken from cars or ambulances. Doors should be of a width to permit easy access of stretchers.

EMERGENCY ROOM

THE EMERGENCY ROOM will be planned and equipped as a minor operating room, but scrub-up and (except in the larger hospitals) utility facilities may be placed in the emergency room. It should have a special medicine closet, poison cabinet, house telephone, electric clock, nurses' call, bulletin board and space for resuscitation equipment. It may also be used for plaster work if no other room is available, but if it is intended for this use a plaster trap will be necessary.

OBSERVATION BEDS

IT IS RECOMMENDED, in hospitals with extremely active emergency services where proper nursing can be assured, that a few beds be furnished in this area for patients in shock, for moribund patients and possibly for accident patients suspected of having communicable disease.

OFFICE AND WAITING ROOM

AN OFFICE AND WAITING ROOM for the emergency section is suggested for all but the smallest hospitals, to be convenient to the emergency entrance and to have a public telephone.

Areas in Sq. Ft.	50-Bed	100-Bed	150-Bed	200-Bed
EMERGENCY DEPARTMENT				
EMERGENCY				
Emergency operating room	280	280	280	280
Office & waiting room	—	—	80	80
Bath	—	—	50	50
Toilet	20	20	20	20
Utility room	—	—	—	45
Storage & supply closet	45	45	45	45
Stretcher & wheelchair closet	25	25	40	50
Observation beds	—	—	—	205 (2)
Total	**370**	**370**	**515**	**775**

BATH

A BATH MAY BE DESIRABLE in the emergency department. This should be on a pedestal and free-standing on three sides. A separate shower is also desirable.

TOILET

A STANDARD TOILET ROOM is required in this area.

UTILITY ROOM

STANDARD OPERATING ROOM utility facilities, with emergency sterilizing equipment, should be furnished in a separate utility room in the larger hospitals. The sterilizing equipment in either case will be minimal, inasmuch as routine sterilization will be done in the central supply room. An instrument sterilizer, a general utility sink with knee or elbow control, work counter and necessary cabinets will be required.

STORAGE AND SUPPLY

STORAGE SPACE will be required for supplies, dressings, trays, anesthesia apparatus and anesthetic gases. Storage space for splints and plaster bandages will have to be furnished if the emergency room is intended for use as a plaster room.

STRETCHER AND WHEELCHAIR SPACE

SUFFICIENT SPACE IS NEEDED for one stretcher and one wheel chair. Shelves may be placed above the level of the wheel chair and stretcher for additional storage space.

SECTION ON SERVICE DEPARTMENTS

Next month's article in the series on hospital planning prepared by the Division of Hospital Facilities will take up the service departments, including dietary department, laundry, housekeeping and storage facilities.

Blue Cross Payments

Pose a Problem in Cooperation

E. A. VAN STEENWYK

Executive Director
Associated Hospital Service of Philadelphia

THERE is no easy or simple way to arrive at a method under which a Blue Cross plan and its member hospitals can agree upon a hospital payment schedule. It does not help the situation to say that a plan is merely the "agent" of its hospitals and therefore must do the hospitals' bidding or that hospitals are only half of the "membership" of a plan and that because of this it must be independent. In truth, hospitals and plans are partners and should work together in the patients'-subscribers' interest. Their differences can only be resolved on the basis of thoughtful and sympathetic consideration of the problems of each.

Some of our more recent misunderstandings have been caused by the varying uses of such terms as "costs," "charges," "receipts," "surplus" and "reserves." In addition, we seem to have lost sight of the wide range in hospital practices on charges, admission policies, items included in cost, character of plant and facilities and financial standing, even within one community.

For instance: It is hard for most people to realize that hospital rates for the same services vary as much as 100 per cent within the same community. Why this is true and why in some instances it might even be proper largely make up the difficulty of establishing a satisfactory schedule of payment to hospitals by Blue Cross.

Payment Geared to Billings. So far three methods have been used by plans to pay hospitals. The first and most generally used method is to translate average hospital charges by member hospitals into a payment schedule by days. This can be done by many devices. Some plans use a straight per diem; some use a per diem weighted in accordance with length of stay (the short, more costly stays up to 11 or 12 days being paid for at higher rates than are longer stays); others use a schedule having the payment schedule weighted in accordance with type of case, *i.e.* surgical case rates as opposed to non-surgical or maternity. Some plans pay hospital charges as billed less a discount but with a ceiling on the overall per diem paid to all hospitals. Some plans offer subscriber indemnity contracts on either board and room or other services.

These devices, while "geared" to hospital charges, do not pay hospitals their charges. Total charges are merely the reference point to which total receipts from the plan and subscribers are compared with receipts from non-plan subscribers or hospital costs. More recently, certain plans have gone all the way in this method and have agreed to pay member hospitals their regularly posted rates for all services provided subscribers.

Any of the variations under this payment method (related to charges) is thought to be successful by hospitals to the degree that payment to each member hospital approximates the charges which each would have made to non-plan subscriber patients if every patient had paid all charges; by plans, to the degree that they are able to balance their budgets.

Payment Geared to Costs. The second method is to pay hospitals on the basis of costs. This method is not in general use because, for one reason, it requires all member hospitals in the plan to adopt the same accounting methods. While the American Hospital Association has formulated a standard classification of accounts and standard accounting procedures, relatively few hospitals have adopted either the account classifications or the accounting methods recommended.

The most effective of the criticisms directed against this method of payment is the assertion that the "cost" method of payment rewards poor management and penalizes good management. If a hospital has a poor plant which makes efficient management impossible, if its personnel practices are indifferent or unbusiness-like, if it has an unintelligent capital structure which weighs down the hospital, Blue Cross under the "cost" plan of payment would pay more. On the other hand, if the hospital plant is efficient, its personnel practices designed to get maximum efficiency from each worker and its capital structure sound, Blue Cross under the "cost" system of payment would pay less.

In defense of the criticisms of this method it may be said that while hospitals are for the most part operated upon a nonprofit basis, their managers, as in any other business, want a chance to show results, to gain distinction by improving service and thus make the hospital's place in the community more secure.

Management in the hospital reveals itself as in any other enterprise: in the spirit of the institution, in more attractive rooms, food that is tastefully prepared and intelligently served, a friendly and cooperative attitude of employes toward patients and visitors. While these are some of the things that make up the genius of management in a hospital, the analysis of such qualities is not easy.

To those opposed to this principle of payment, such improvements seem less possible under a "cost" basis of payment. Another difficulty of this method lies in the fact that hospitals operated by religious orders find it extremely difficult properly to evaluate the "cost" of the contributed services made by those who devote their lives to serving the patients directly or managing such institutions.

There is, in addition, a trend of thought among hospital administrators at the present time to assume that, if a hospital's costs are high, its services must be especially good and its management particularly skillful. Yet higher costs do not necessarily mean higher quality serv-

ices or skillful administration. What the extension of this trend of thought might mean to a plan paying hospitals under a "cost" basis is not a source of encouragement to the idea.

"Agnew" Method of Payment. The third method, suggested by Dr. Harvey Agnew, would pay each hospital on the basis of the services provided by each hospital. Thus, a hospital providing all services included in the subscriber's agreement would be paid at a higher rate than would a hospital having only two thirds of such services available. Dr. Agnew went further in suggesting that hospitals that offer qualitatively better services be paid higher amounts than those offering lower quality service.

Quality of service under the Agnew method would be determined on an objective basis in much the same manner as quality of service now ranks hospitals under the American College of Surgeons hospital standardization program. "Does it keep medical records on each case?" "Is its radiology department managed by a diplomate of the American College of Radiology?" "What is its medical staff organization?" "What kind of a laboratory does it have?" And many other such considerations.

No plan is now paying hospitals under the Agnew basis, and its advocates may therefore freely insist that its universal adoption would bring in a new era of satisfaction. It may be assumed, however, that the objective standards by which hospitals are rated under the Agnew system are not as easy to apply as it may appear. As an instance: There are many governmental hospitals which, under the Agnew method, would rank with the highest grade in any plan. Even though such hospitals provide care through a private medical staff, the public will in most instances be willing to pay a premium of $4 or $5 a day for nongovernmental hospital care within the same community.

Any of these three methods of payment will be equally satisfactory and any will be equally unsatisfactory depending upon the understanding and good will of the member hospitals and the Blue Cross plan. If hospitals are critical of payments made by Blue Cross on a basis geared to "billings," they will be equally critical of a payment method geared to "costs" or the Agnew method. The method used in each instance tried honestly to pay the amount that the hospital should receive for services provided to subscribers.

Huge Enro'lment of Blue Cross Has Changed Outlook of Hospitals and Plans. When Blue Cross plans began, the American Hospital Association and everyone in hospital work fell to the task of developing the idea with enthusiasm and imagination. Here was an opportunity to provide a public service and a much needed business reformation in hospitals. But times have changed and the thinking and planning of ten years ago are no longer adequate. Since then 26,000,000 subscribers have been enrolled. In many communities as much as 50 per cent to 60 per cent of the population are members of Blue Cross. The problems facing hospitals and plans today are utterly different from those which faced them 10 years ago.

Part of the difference has been caused by Blue Cross, part by advances in medicine and part by improved standards of hospital administration. Blue Cross has made it easier for people to get hospital care when they need it, has popularized the idea of going to the hospital early, not waiting until it is too late, and experience under the plan has greatly lessened the public's fear of hospitals. The advances in medicine have given hope and confidence to sick people who would otherwise have faced invalidism or chronic ill health. Improved standards of hospital administration have made a start toward making patients feel welcome, so that they want to return when necessary.

The basic truth is that Americans having had a taste of good hospital care want more of it, not less. All planning of hospitals and Blue Cross must take this greatly enlarged market into account. This is a new time and the time calls for a revision of some of our procedures and points of view.

What Does the Hospital Want? What does the hospital want from Blue Cross for a comprehensive service contract? This is a simple enough question and it can be answered simply. The hospital wants to be paid what it would otherwise bill its paying patients for the same services. Yet if a Blue Cross plan pays hospitals on an "as billed" basis, it will be agreed that each hospital must post with the plan its schedule of rates then in effect. Without this Blue Cross would have no basis upon which to check its bills. It would also be agreed that the schedule of rates given by each hospital must be adhered to by the hospital and may be changed only upon giving proper notice and opportunity of review by the plan.

Can Blue Cross Pay Hospitals on an "as Billed" Basis in the Long Run? While at the inauguration of such a method of payment the first schedule of rates may be accepted without question by the plan, the succeeding changes in rates must result in differences of judgment as between the plan and the hospitals. Let's consider an example: Fifty hospitals are members of a plan. Agreement is made to pay hospitals on an "as billed" basis and the hospitals under an agreement post their rates with that plan.

Room 202, a two bed room, in Hospital A is valued at $6 a day. Penicillin is regularly sold to patients at $2 per hundred thousand units. An x-ray of the wrist is charged for at $5. The operating room fee is $10. In Hospital B, room 202, a two bed room, is valued at $7 a day. Penicillin is regularly sold to patients at $5 per hundred thousand units. An x-ray of the wrist is charged for at $10. The operating room fee is $15.

A and B are both general hospitals. Both would rank high under any analysis. Both are in the same section of the community and may have practically the same medical staffs. Their rooms are equally attractive, their food is equally desirable and their employes are equally pleasant and cooperative. Each has a good medical staff. Each offers essentially the same type of service and has the same percentage of maternity, surgical and medical cases.

Move forward now and suppose that payment on an "as billed" basis has proceeded for a year, and that both Hospital A and Hospital B are satisfied with its operation. Hospital A, however, discovers from the report of the plan and by observation that Hospital B has received considerably more for the same services than A has received. Hospital A then adjusts its rate schedule in accordance with the rates of Hospital B and notifies the plan that the changes in rates are based upon (1) increases in costs and (2) the real-

ization that Hospital B has obtained these rates for the last year. A committee of the board of directors of the plan studies the suggested rate schedule and decides that this is a proper increase and so notifies Hospital A.

At this point Hospital B, because it has always received approximately 20 per cent more than Hospital A for the same services and has over the years confirmed its belief that its services are worth 20 per cent more (all do), decides that it, too, will adjust its rates upward by 20 per cent over its present schedule and the newly accepted schedule of Hospital A. Again this is referred to a committee of the board of directors of the plan which studies the suggested change, but in this instance because it cannot distinguish a difference in the quality of service offered by the two hospitals, it decides that this is not a proper increase and notifies Hospital B to this effect.

It is at this point that the whole theory of payment on an "as billed" basis breaks down. The committee of the board of Blue Cross must now inquire into the relative merits of the services which each hospital is providing. The board of directors of Hospital B has a right to require the directors of the plan to justify its denial even though the plan may have neither the authority nor facilities for making such inquiry. If it inquires into the relative merits of each hospital's services, it must analyze the character of the management of these hospitals, and if it does no more than raise an eyebrow over an assertion made by Hospital B, this is sufficient forever to deny the essential which hospitals have required of Blue Cross—freedom of action in management.

Hospitals are public business. They are not private ventures, yet management in hospitals is now free and unburdened by outside controls. It is my belief that no faster method of bringing an outside agency into hospital management could possibly be devised than to require Blue Cross to pay hospitals on an "as billed" basis. Moreover, as the percentage of enrollment in Blue Cross or any other prepayment device is increased this problem under such a method of payment will increase and become more and more complicated.

Deferring the day when the full impact of an unsound practice must be borne by the community and member hospitals will not lessen its force but increase it. There is no magic in Blue Cross. There are only so many cents in a dollar. Blue Cross cannot offer a blank check to hospitals any more than it could to any other organization and expect that it will not be filled out.

Do Plans Need Service Contracts or Guarantee of Service? It may be argued that service contracts though desirable when plans were starting are now outmoded, that since plans have reserves and since subscribers are now able to pay the differences between what the plan pays the hospital and its regular charges, service contracts are no longer necessary. Also, it may be argued that the success of Blue Cross in pioneering in better insurance contracts for hospital care has established new standards which commercial insurance plans have adopted. It may be argued that these standards once adopted by commercial insurance will be carried on by commercial insurance and that the special interest of hospitals in Blue Cross is therefore no longer necessary.

One may even hear that while it is easier for the hospital to deal with Blue Cross and while the subscriber is better satisfied, the hospital comes out better under the indemnity plan of commercial insurance because it may charge the insured for all services at regular rates, the policyholder being obliged to settle with the insurance company.

As to the first question, whether service contracts are essential, the answer is to be found in the success of Blue Cross in the enrollment of 26,000,000 subscribers—the product, a service contract sold these subscribers —and only the product will keep them sold. There may be some doubt whether the member hospital guarantee need be continued once reserves have been established. But it should be remembered by the hospital that without such a guarantee the concept of Blue Cross as an arm of the hospital is no longer justified. Under such a concept there appears to be no reason for close integration of Blue Cross management and hospitals. Also, state and federal laws granting tax exemption to Blue Cross (which is in the subscribers' and hospitals' interests) are in no small part based upon this concept.

Are Blue Cross Reserves Too High? It has also been said that the reserves of certain Blue Cross plans are "too high," that the size of the reserves reflects an unnecessarily conservative attitude on the part of plan management and that if reserves requirements were not as high, hospital schedules would be much higher. As to the first assertion that reserves are "too high," the individual plan's board of directors and the state insurance commissioners must necessarily be the judge. But, in addition, the Commission on Hospital Service of the American Hospital Association has set up standards which may be applied to the reserves of any Blue Cross plan.

Under the standards adopted, a plan may be regarded as fully reserved when its reserve for contingencies equals eight times the average amount of the monthly hospitalization demand for the previous six months. Comparisons of the reserves of most Blue Cross plans with the standards set by the commission will not confirm the point of view that reserves are excessive. Locking the stable after the horse has been stolen won't help hospitals or the community if a conservative attitude has not been adopted. The board of directors of a Blue Cross plan which too casually gives way to high pressure tactics for increased hospital payments without adequate subscriber rates will find the same hospitals the most critical of its management if the plan's resources cannot meet its bills.

Reserve funds, surplus, net worth —call it what you will—in nonprofit Blue Cross plans can be used for only three purposes: to pay hospital bills, to increase subscriber benefits and to reduce subscriber rates. The members of the boards of directors of Blue Cross are as interested in the financial health of hospitals as are the hospitals themselves. Many are presidents of hospitals and not a few are hospital superintendents. These directors have sought to protect the resources of plans because hospitals will desperately require such a backlog when purchasing power of patients is reduced.

Responsibility of Blue Cross to Subscribers. Blue Cross is administering funds of its subscribers. The plan therefore has an equal obligation to the subscribers and to the hospitals. As agent for its sub-

Hospital Charges Compared With Veterans Administration and Workmen's Compensation

SERVICE	REGULAR CHARGES AMONG TEN LARGEST HOSPITALS			VETERANS ADMINISTRATION SCHEDULE	WORKMEN'S COMPENSATION SCHEDULE
	HIGH	MEDIAN	LOW		
Delivery room	$10.00	$10.00	$ 5.00		
Anesthesia for delivery	10.00	5.00	no charge		
Cesarean	25.00	15.00 and 10.00	5.00		
Circumcision	10.00	5.00	2.50		
Operating room—Major	15.00	10.00	5.00		$10.00
—Minor	10.00	5.00	2.50		5.00
Anesthesia—Major operations	15.00	10.00	5.00	$5.00-$20.00	10.00
—Minor operations	5.00	2.50	.....	0- 10.00	5.00
Cardiograms	15.00	10.00	5.00		10.00
Basal metabolism	10.00	5.00	2.00		5.00
Intravenous solutions—Normal saline	4.00	0.75	0.50	Cost plus $3.00	Cost plus 25%
—Dextrose	4.00	1.00	0.50	Cost plus $3.00	Cost plus 25%
Oxygen	10.00	6.80	5.00		Cost plus 25%
Laboratory charges:					
Pneumococcus typing	8.00	5.00	2.00	3.00	5.00
Coagulation time	2.75	2.00	1.00	.....	1.00
Sugar tolerance	10.00	5.00	2.00	5.00	7.50
Blood Wassermann	5.00	3.00	2.00		& Kahn $5.00
Spinal fluid	15.00	5.00	2.00	2.00	3.00
X-ray:					
G. I. series	50.00	40.00	30.00	25.00	40.00

scribers Blue Cross must be sure that payments made to hospitals are reasonable and that they are in line with the amounts collected by hospitals for similar services to nonsubscribers or other agencies. It must also keep its subscriber rates low enough to attract the majority of the citizens of any community. If the subscriber is not assured that Blue Cross is prudent in his behalf, he will select another prepayment device. He may also demand a governmental insurance plan. The hospitals are already doing business with the state, with the federal government and with insurance companies. They also do business directly with the public. The facts appear convincing that in general none of these groups pays as high a rate as do Blue Cross subscribers if the payments made by the subscriber (for private rooms and other "extras") are added to the amount paid by the plans.

Same Rates for Same Services? While the times call for new approaches, how to pay hospitals at fair rates is an old problem and might be solved by using devices that have been used before. If hospitals desire to be paid on an "as billed" basis and overwhelmingly indicate their desire to be paid in this manner, the plans can work out a method whereby hospitals will be paid in this way. The same rates for the same services are, however, a prerequisite under such a method of payment.

The notion that is expressed in the usual "as billed" payment request from hospital administrators which suggests that it is proper for a Blue Cross plan to pay one hospital 50 cents for a laboratory procedure and another $5 for the same procedure is so fantastic one wonders how it could ever be considered. It is also a vain hope that commercial insurance will write policies which make this possible.

It may be argued that all hospital service is not worth the same amount. It is true that many laboratories are better equipped than other laboratories and that the skills of the pathologist and the technician employed in the laboratory are important attributes which ought to be weighed into the price policies of hospitals. Yet there are limits to which even general truths of this character can be pushed.

If the hospitals have found it reasonable that the federal government pay them at standard rates for the same services, as under the Veterans Administration program, and if the hospitals have established schedules of charges for Workmen's Compensation cases, why is this not an equally desirable method for Blue Cross? The method has been tested, and there is no reason why a group of hospitals within a community could not agree upon the same prices for Blue Cross and the general public on the services they offer.

If a hospital has rooms that are acknowledged as superior to the rooms of other hospitals in the area, and the other hospitals are willing that it should receive more for these rooms than is received for the others —so be it. The working out of such a method of payment is not the responsibility of Blue Cross. It is the hospitals'.

Old Methods With a Ceiling Classification. A second possibility along these lines which might be adopted by member hospitals and Blue Cross plans is to grade member hospitals so that payments made by plans to each hospital will be made on a level that is consistent with the other hospitals in the same grade. If plans and hospitals could agree upon comparable rates for approximately the same services; if the hospitals in each plan were rated in accordance with existing standards, (a) those approved by the American College of Surgeons and (b) unapproved hospitals, and if an annual per diem ceiling could be agreed upon for the hospitals in each of these grades, much of the present dissatisfaction with payment schedules could be overcome.

Result of Survey. While many hospital administrators assume that the Workmen's Compensation schedule and the Veterans Administration schedule are less than their regular over the counter charges for paying patients, we were surprised by the results of the recent study which we undertook of the charges by items of services in the 10 largest hospitals in the Philadelphia area. The results of a study on semiprivate charges of certain large items of expense in comparison with the Veterans Administration and Work-

men's Compensation schedules are shown on the accompanying schedule on page 74.

Blue Cross plans are their member hospitals' partners. They stand ready to work with hospitals, as they already have, not only by seeing to it that their payments shall be made consistent with the needs of hospitals, but by cooperating in the education of their 26,000,000 subscribers, the legislature and the nation as a whole in regard to the problems of the hospitals, so that in reason and with amity hospitals may move forward to accomplish their great purpose.

How much should Blue Cross pay hospitals—50 cents a day more—or $1 a day more—or even $2 a day more than the current rates? No one can say because the pattern is too confusing. Certainly if hospitals work together with Blue Cross to find out a reasonable answer, and it is determined that present subscription rates are inadequate to meet the necessary payments to hospitals, Blue Cross can then approach subscribers with an understandable story.

How should hospitals be paid? I believe that a satisfactory system may be geared to charges, costs, qualitative analysis of the services rendered by each hospital, such as proposed under the Agnew method, or on a schedule of charges for each item of service, as is suggested here.

Each method, however, imposes its own requirements and limitations. Neither hospitals nor plans can expect to have their cake and eat it too. Each method requires that all of the hospitals in the plan be paid under the same method though all would not necessarily receive the same amount per day or per case. The present tendency of Blue Cross plans to offer choices in payment methods to member hospitals cannot but result in disaster because each choice made by each hospital is made against the plan. In addition, the self limiting factor which such choice imposes upon the alternatives so made available makes them unattractive to hospitals.

Hospitals face serious problems. Food costs have risen, salaries have risen and much equipment and many facilities need replacing at higher than their last cost. It also appears that because hospital salaries will be still further increased these costs will continue to rise. Yet hospitals are better off today in collections, in number of patients, in public relations and staff support than they have been within the memory of most superintendents now active.

If this has been accomplished in large part by a more reasonable approach to the payment of hospital bills of a segment of the population —the percentage enrolled in Blue Cross—which I believe to be true, might not the application of equal imagination and energy to some of the other problems of hospital finance result in equally general improvement in hospital economy?

It is my belief that if the same kind of attention which hospitals gave Blue Cross during the last ten years were now directed toward (1) coordination of hospital facilities and elimination of wasted hospital effort within each community and toward (2) obtaining support for free work upon an adequate basis, most of the jangled nerves revealed by those negotiating contracts with Blue Cross would vanish overnight. Because the truth is that the hospitals' financial problem is not the result of Blue Cross.

Hardly a week passes but a hospital administrator makes the suggestion that something should be done about the coordination of hospital facilities within the community. This is the whole community's job, not just the hospitals'. The development of hospital councils adequately supported and ably staffed in every large community is vital.

Here is a community, for instance, that has excellent general hospital facilities, hospitals that are well situated geographically and well staffed and managed. But hospital facilities are not available for convalescent patients. Do the general hospitals, which are gradually becoming more and more crowded and which need the space occupied by the chronically ill and convalescent patients, get together to see what can be done to obtain relief from this problem? They need such relief if their per diem income is to be increased. Yet this is not done. Instead, even though one of the local hospital administrators tries to work out an approach to the problem on a community-wide basis, the hospitals in general reveal an unwillingness to provide sufficient information for long term planning.

Here is another community in which the public is of the opinion that thousands of beds are needed though every survey made by responsible surveyors indicates that the true solution to the shortage of beds lies in part in the expansion of outpatient facilities. Why is nothing done about this? If the people will pay for bed care, they will surely be willing to pay much less for outpatient care. Organized medicine is sometimes blamed wrongly, I believe, for the hospitals' unwillingness to expand outpatient facilities. The doctors need the beds for sick patients and would readily support an extended and coordinated outpatient setup.

Here is another community with hospitals so old and run down that it is a wonder that management can get any kind of performance at all. The obvious answer again is coordination, elimination of duplicated facilities, joint capital fund raising and even probable joint financing on the basis of loans from insurance companies or other investors. If the Metropolitan Life Insurance Company, for instance, finds it profitable to invest in low cost housing units, it would find it equally profitable to invest in a community's voluntary hospital system if it is fully coordinated and if all uneconomic practices have been removed.

If hospitals were all that we hoped they were; if patients were getting good food and pleasant surroundings, courteous treatment from employes and doctors; if hospitals were not crowded and if all were clean and well kept, hospital administrators might have reason to look the world squarely in the eye and lay the blame for all of their troubles at the door of Blue Cross.

All over the land hospitals are now threatening withdrawals from plans—or are actually withdrawing. Yet inquiry into the basic problems of hospital financing and organization, as may be observed, is resisted —not encouraged. The recent alliance between a state hospital association and a health and accident insurance federation to force a Blue Cross plan to pay hospitals on an "as billed" basis is the latest in a long series of incidents of this type that strike at the fundamental strength of the voluntary hospital system.

Blue Cross, the carefully built up and unique structure of voluntary

health insurance, which has taken the devoted effort of community leaders, hospital trustees, hospital administrators and the officers and directors of the plans for the last ten years is in danger. It will continue in danger as long as the vain hope persists that some kind of magic instead of the advantage gained from nonprofit operation and low operating costs will make Blue Cross able to pay higher rates than the amount either regularly paying patients or commercial insurance companies now pay.

Blue Cross is an insurance device for the millions. It has tremendous potential for good as long as all who have a voice in its direction keep their feet on the ground. There is no room for wishful thinkers in its councils. There is no time for petty obstructionists who want to solve all of the problems of financing hospital care at once and under a set of impossibly contradictory requirements.

There is no hope for the voluntary hospital system unless the leadership of our hospitals stops its present double-talk. The double-talk which says to the listener that hospitals understand how a sound Blue Cross plan should operate yet insist upon individual treatment without any limit for each hospital that wants something different is today's great peril. Unless it is corrected this kind of double-talk will result in the abandonment of nonprofit hospital insurance. The next question? It is squarely before American hospitals. Can voluntary nonprofit hospitals continue existence without nonprofit hospital insurance?

Medical Administration as a Career

THE progressive enlargement of the field of administrative medicine since the beginning of the present century is due, in the opinion of Dr. J. M. McIntosh, who is dean of the London School of Tropical Medicine, to the growth of institutions for the care of the sick, enriched since 1929 by the transfer of poor-law hospitals to the major health authorities, and to the great expansion of the public health services during the same period. The evolution of a National Health Service [in Great Britain] will foster the demand for administration under the regional hospital system. In planning for the future, the academic duty of training medical men and women in the principles and practice of administrative medicine must therefore be accepted now.

Writing on "Medical Administration as a Career," in the *Lancet* (May 1946), Dr. McIntosh points out that there is a clear need for lay administrators, for whom there are already excellent courses of instruction in public administration, and advises that they be given more specific training and apprenticeships in institutional management.

The need for training medical men and women in medical administration has not been fully recognized and doctors with clinical interests have been slow to appreciate the value of this specialty or to realize its worthiness as a career.

Medical administration is described as extending into many fields, including institutions for the sick, the public health services, the social services and the organization of the medical profession itself under the new national proposal. Academic training alone is not sufficient in some of these divisions and the author advises combining it with practical experience in the nature of an apprenticeship. There is also a need for certain basic training, upon which foundation experience in particular departments can be built. Special training, it is emphasized, is needed for the medical administrator, as in other specialties, but the curriculum of the medical school is itself a necessary foundation for a career in medical administration.

The author sees no reason for conflict between lay and medical administration. The medical administrator must be responsible for the coordination of medical services to the sick, for hygiene in its broadest sense, for the interpretation of medical decisions to the governing board of the institution and, above all, for the well-being of the patients and their friends. The function of the medical administrator must be, the author says, to adapt the hospital to the needs of the sick, not the sick to the traditions of the hospital.

Problems of technical and domestic services in a hospital are similar to those of a large hotel and the many aspects of these problems are the province of the lay administrator. Among the duties of the medical officer should be the interpretation of the problems of lay administration to the medical staff. It is emphasized that it is essential to understand that the administrative medical officer is a specialist in his own sphere.

An outline for the career of an administrative medical officer is given in the article. It is advised that he spend at least a year as an assistant in general practice, followed by a senior residency with administrative duties in a smaller hospital, during which facilities should be provided for taking the course for a "diploma in medical administration." The diploma, after one year of academic study and one year of supervised apprenticeship, would then qualify the officer for a recognized post of junior grade in the hospital service or in the field of public health or industrial medicine according to his inclination. From this point he would be promoted through the organization to a part in a teaching hospital or headquarters of a region.

Brief comparison is drawn between present courses in England and those given in the United States. The author concludes by advising a recognized course of academic training, followed by practical experience through an apprenticeship system leading to a diploma in medical administration at the end of two years. He defines medical administration as wider in scope than hospital administration and feels that the diploma should cover a more extensive field of study and practice.—HENRY B. MAKOVER, M.D.

PEOPLE IN PICTURES



Alden B. Mills, administrator of Huntington Memorial Hospital, Pasadena, and western editor of The MODERN HOSPITAL, discusses his National Hospital Day broadcast with Sarajane Wells, star of N.B.C.'s "Woman in White" program, and Robin Black, who is the producer.



"Who should pay the doctor bills?" was the topic of a *New York Times* radio forum, "What's on Your Mind?" Participants were, l. to r.: Dr. Ethel E. Wortis, chairman, Woman's City Club public health committee; Louis H. Pink; Iphigene Bettmen and Alice Pentlarge, co-moderators; Dr. Ernest P. Boas, and Michael M. Davis, Committee for the Nation's Health.



Left to Right: Stuart G. Aldhizer, administrator, Lewis-Gale Hospital, Roanoke, Va.; Dr. Henry G. Farish of the American College of Surgeons, and William H. Markey Jr., A.H.A. accounting specialist, at a recent meeting.

Below: Governor Pastore of Rhode Island signs the Workmen's Compensation Act amendment which increases payments to hospitals. Looking on are Kenneth D. MacColl, Oliver G. Pratt, Carl A. Lindblad.





Members of the American Nurses' Association who welcomed visitors to the International Council of Nurses. Front Row: Mary M. Richardson; Effie J. Taylor, retiring president of the I.C.N.; Edith M. Beattie. Back Row: Florence M. Johnson; Mrs. H. R. Norsworthy; Winifred Kaltenbach; Elisabeth C. Phillips; Ruth W. Hubbard.

Nursing Survey Shows Variation in Salary Pattern

In this group of small hospitals, the nursing service is evenly divided between graduate and practical staffs

THERE is little uniformity among hospitals today in the ratio of graduate nurses to patients or in the relationship of graduate nurses to nonprofessional workers, such as practical nurses or nurse's aides.

In a group of 17 small hospitals polled on nursing service recently, the graduate nurse-patient ratio varied all the way from a hospital employing only one graduate nurse to care for a daily average of 23 patients to another hospital with 16 graduates on the staff, including head nurses and supervisors, and an average daily census of 30 patients.

As the accompanying table shows, however, the usual ratio in these hospitals is one graduate for every four or five patients. Since the figure given includes head nurses, surgical and other supervisors, as well as both day and night general duty floor nurses, the adequacy of the service should not be so readily assumed as one might think at first. As a matter of fact, an analysis of the replies which furnish a detailed breakdown of how graduates are employed indicates that the number of general

NURSING SERVICE IN 17 SMALL HOSPITALS

Hospital	Daily Patient Census	Total Graduate Nurses Employed	Number Practical Nurses Employed	Ratio of Grad. to Prac. Nurses 1 Year Ago	Salary Range Grad. Nurse Staff	Pct. Sal. Increase in Last Year	Salary Range Prac. Nurse Staff	Hours per Week Graduate	Hours per Week Practical	Anticipated Changes
1.	30	4	7	More grad.	not stated	15	$130†	not stated	48	not stated
2.	69	17	29	Same	$150–$180(1) 160– 190(2)	20	$50†–$90†	48	48	not stated
3.	30	10	5	More grad.	$150†–$180†(1) 180 – 210(2)	None	$100–$120	48	48	not stated
4.	75	25	10	More grad.	$140†(1) 150†(2)	20	$85–$100	48	48	None
5.	44	10	0	More grad.	$145†	3	$35†–$85†	not stated	not stated	None
6.	29	12	4	Same	$140†–$150†	12	$50†–$90†	48	48	Shorter week
7.	100	19	6	Same	$130–$150(1) 155– 175(2)	15	$73†–$94†	40–52	48	not stated
8.	47	15	14	Same	$160(1) 180(2)	not stated	$100–$125	45	not stated	None
9.	40	9	19	More grad.	$160–$175(1) 175–250(2)	— 20	$70†–$110†	48	56	None
10.	30	16	14	More grad.	$150†(1) 185†(2)	10	$75†–$110†	40	40	Incr. Sal. Grad. Staff
11.	65	17	7	More grad.	$150(1) 170(2)	25	$100–$110	48	48	Shorter week
12.	58	15	13	Same	$120†–$130†(1) 155†– 180†(2)	15	$65†–$90†	48	48	Incr. Sal. Grad. Staff
13.	23	1	9	More prac.	not stated	30	$40†–$110†	48	48	None
14.	23	5	9	Same	$192†*	10	$75†*–$125†*	44	44	None
15.	44	19	9	More grad.	$150†–$170†(1) 170†– 185†(2)	20	$100†–$110†	45	45	Shorter week
16.	75	37	9	Same	$145†–$170†(1) 160†– 200†(2)	10	$100†–$143†	48	48	not stated
17.	16	7	7	Same	$150–$175(1) 175(2)	Same	$90–$120	44	44	None

†With meals or other maintenance.
(1) General floor duty.
(2) Supervisory duty.
*Includes bonus (see text).

duty nurses on daytime duty is one to every nine patients—still a more favorable ratio than many hospitals can manage today.

As the figures indicate, there is no pattern either to the number of practical nurses employed. In some cases it is twice or more the number of graduates; in others few, if any, nurse's aides are used. The average is about three practical nurses for every four graduates. Eight of the hospitals taking part in the forum indicate that the ratio of graduate to practical nurses is higher today than it was a year ago, that is, more graduates are available and employed now. A like number have had about the same ratio of graduates to aides throughout the last year, and only one hospital has a higher proportion of practical nurses now.

Salaries paid to graduate nurses and supervisors are up substantially over a year ago, as the figures show. The lowest salary paid to graduate nurses in this group of hospitals is $120 a month (and to this should be added an unspecified amount of maintenance) and the highest is $192 (plus meals). Supervisors draw from $150 to $250, with some maintenance added in both cases. Average of all the salaries now being paid in these hospitals is $154 for general duty graduates and $178 for supervisors, plus some maintenance in both cases.

One interesting salary arrangement is described by an administrator who pays a bonus to all employes who have been employed continuously for twelve months prior to July 1 each year, when the bonus is paid. Introduced to reduce personnel turnover, this bonus system has been in successful operation for three years now. The amount of the bonus has been approximately 20 per cent of the annual salary, it is reported.

All but three of the hospitals in the group are paying higher salaries now than they were paying a year ago. The increases range from 3 to 30 per cent, and the average increase is 16 per cent.

Of the three remaining hospitals, one did not reply on this point, one reports salaries about the same as a year ago and the other reports an astonishing 20 per cent decrease in salaries during the last year. The circumstances are not stated.

Practical nurse salaries are hard to determine from the figures given here, since, obviously, some of the stated salaries are for less than full time employment. Averaging the maximums given, however, on the theory that these are all full time figures, one gets $109 a month. The average of the stated minimums is $75. In all but four cases, the salaries are supplemented by meals or other maintenance.

As the table shows, only one hospital in the group has graduate nurses on a 40 hour week, although one other institution reports that some nurses are on the 40 hour schedule. Most of the hospitals report graduate staffs working 48 hours, with a few at 44. The average working week for graduate nurses employed in these hospitals is approximately 46.5 hours.

Practical nurses (on full time) work about an hour a week longer, on the average, than do graduate nurses in these hospitals. Only one institution reports a 40 hour week for this group of employes, while another hospital reports 56 hours. The average is 47.3 hours.

Two thirds of the hospitals responding to the forum do not anticipate any marked change in salary or working hours of nurses in the future, or in the proportion of graduate to practical nurses employed. Of those administrators who do feel that further changes are in prospect, several expect to reduce the working week for nurses and nearly as many expect that further salary increases to the graduate staff will be needed. Of those looking for a shorter week, all but one now have nurses working 48 hours; in the other hospital, nurses are now working 45 hours and a reduction to 40 hours is planned.

The two hospitals which expect to increase salaries for graduate nurses are near the bottom of the scale now, averaging $125 and $150 a month.

Charges for Polio Care

LOOKING forward to the possibility of having cases of poliomyelitis admitted to the hospital during the coming summer, Concord Hospital, N. H., has offered to the Merrimack County chapter of the National Foundation for Infantile Paralysis the following program for caring for such cases:

Cases of poliomyelitis will be admitted to the Margaret Pillsbury Unit of Concord Hospital to the two single rooms and the four bed rooms at the west of Hall 2. The hospital will employ such nurses as are necessary to care for the cases admitted. The salaries of these nurses will be kept separate from the regular nurses' salaries and bills for their services will be rendered to the Merrimack County chapter. These bills will detail the patients for whom each nurse cared during her tour of duty in the hospital.

Nurses with training and experience in the care of poliomyelitis cases will be paid $50 more a month than the regular staff duty nurse. Nurses with no formal training but with some experience in caring for such patients will be paid $30 a month more than the regular staff duty nurse. Nurses with no previous experience in caring for polio cases will be paid $15 a month more than the regular staff duty nurse. This unit and these nurses will be directly under the supervision of the assistant director of nurses in charge of the Margaret Pillsbury Unit.

As an offset against the cost of nursing service, which will be charged directly to the chapter, the hospital will reduce the usual day rate for these patients by one sixth and will charge this amount, plus the extras, to the individual patient up to that patient's ability to pay for care.

The decision as to the patient's ability to pay for care shall be made by the Merrimack County chapter of the foundation. The remainder of the bill covering charges for room and board and extras will be charged to the Merrimack County chapter.—N. CONANT FAXON, *administrator, Concord Hospital, Concord, N. H.*

The Means Are at Hand

for building better public understanding

RAYMOND T. RICH

IT WOULD be interesting to survey the hospitals of the nation to see how many are using the basic technics of public relations. No doubt we would find programs in all stages of development. They might range from the hospital that calls in a news photographer once a year for the nurses' capping ceremony to the hospital which thoughtfully and systematically uses the newspapers, the radio, special literature and public speakers.

These various technics are, however, merely the outer wrappings of a public relations program. They are useful and even necessary. But to attempt to use them without first solving basic problems would be as futile as to endeavor to build a skyscraper on quicksand. To seize long range public relations opportunities, hospitals must first ascertain their needs by scientific methods; then develop in the light of these findings a program which is based upon enlightened conduct.

Public Relations or Publicity

Indeed, that is the basic distinction between public relations and mere publicity. Good public relations requires enlightened conduct, efficient operation and then effective interpretation to the public. In solving problems, or at least in reducing their intensity, there can usually be found some of the richest opportunities for building relationships of lasting value.

The least visible and therefore perhaps the most neglected problems are the internal ones. They have to do with the hospital's relationships to its patients, to its nursing staff, to its employe staff. But, as many administrators have realized in the course of solving internal problems, they extend far beyond the hospital walls in their net public relations result.

Condensed from a paper presented at the Tri-state Hospital Assembly, 1947.

Some of these internal conditions have been inherited from the past and only made acute by the war and postwar upheaval. Some of them are part and parcel of our times. Solving them is difficult but necessary. This is no time for catch-as-catch-can methods. Great public relations opportunities exist for those hospitals that ruthlessly analyze their problems, undertake to solve them and use tested technics to enlist public trust, confidence and belief in the hospital's function.

Your problem No. 1 is that, by and large, nobody *wants* to be your customer! And your parallel problem is that all too many patients look back upon their hospital experience with resentment. Of all the hospital's many publics, not one is so important as the patient who comes within its orbit, usually in time of crisis that tries both body and mind. For the patient, it is a time of pain and anxiety—perhaps the least of which is caused by his physical suffering. When he leaves those hospital walls, will he become a walking ambassador of good will and support of the hospital? Or will he become a well of indifference or resentment that will be multiplied many times over as that feeling is conveyed to his circle of acquaintances?

This problem is not new. But does it not have a new significance at the present time when hospitals must go to the community at large for greater financial support and for voluntary assistance within the hospital?

Side by side with the patient is the problem of his family and his visitors. What emotions will they take from the hospital to their homes and neighborhoods? Will they go away filled with irritation at what seem to be unreasonable rules? Will they take away the memory of what seemed to them callousness and indifference?

It is true that there are numerous means of obtaining the interest and cooperation of the patient and his family. Chief of them are publications which explain hospital rules and the necessity for them, that ask for their cooperation, that enlist their forbearance with conditions that cannot be helped. There can be attractive leaflets calling attention to the history, romance and usefulness of their hospital, with sketches of key personalities. There are other means at hand for building good will and understanding.

It's Everybody's Job

Helpful as they are, however, they mean nothing when the patient and his family meet with indifference or thoughtlessness on the part of hospital personnel. In your hospital does the spirit of kindness surround the patient from the time he enters the door until the time he leaves? A sympathetic nurse, a courteous cleaning woman can mean a great deal to a hospital's public relations. So also can a cheerful tray girl, provided the tray has better food than I have ever tasted in a hospital!

Dr. John Foote, writing on medieval hospitals, remarked: "Patients were admitted from all classes and beliefs without qualification and, once admitted, became *quasi dominum secundum posse domine* or, freely translated, as a master of the house." We need a revival of this spirit of dedication to the patient.

No amount of printed matter, helpful though it can be, will heal the breach when a patient or his visitor has been pushed around. We must employ methods by which the hospital staff and employes are imbued with a full realization of the need for courtesy and kindness, by which they may understand that

they are just as important as knowledge and skill. They must be inspired with real compassion for the human beings who look to them for relief and assurance.

Our growing knowledge of psychosomatic factors in illness fortifies the conviction that the attendant's attitude toward the patient has an important effect on his recovery. This knowledge leaves little place in the hospital for the thoughtless nurse, the indifferent intern, the surly maid. Even the doctor does not always avoid this category. Here, clearly, is a great public relations responsibility for every single person connected with the hospital.

This brings us to a key question. Can we achieve this spirit in employes who are underpaid, insecure, with no outlet for their grievances? For hospitals, the personnel situation is an important influence on its total public relations.

Nurses Have Told Their Story

I imagine that a great collective groan goes up among hospital administrators whenever the nurse shortage is mentioned. But the nurses have done a good job of carrying their side of the story to the public and, if anything, public sympathy is with them. Indeed, I would hazard a guess that although the hospital patient who receives inadequate nursing service may feel some resentment toward nurses as a group, the real brunt of ill will is borne by the hospital.

The economic and morale problems of the nurses must be solved if you are to develop the esprit de corps so essential to the hospital. Some progress has already been made in this field, but not enough. Both heart and head must be applied to overhauling a system whereby a hospital administrator must offer a nurse a smaller salary than is paid to a secretary-stenographer just out of school; a system which demands that she take part of her pay in maintenance which she may not be able or prefers not to use.

Government services and industry have already made heavy inroads on the nurse supply; the hour is late. Can the hospital field find enough administrators in its midst courageous enough to experiment with nurse hours, working conditions, amount and method of compensation? Since already there are pioneers in the field, have you set up some kind of machinery for sharing the results of experimentation in this area?

The public relations implications of the nurse situation are far reaching. For instance, there can be little doubt that these conditions and the fact that they have become widely known are factors in the low attraction the nursing profession has had for young women in recent years. Add to this the use of student nurses as cheap labor by most hospitals, their long hours of study and work, the rigid rules by which they must live, and it can well be understood why in 1946 only 25,000 students signed up for nursing schools when there were 15,000 more openings.

In medieval hospitals, board and clothing were provided the nurses, but no salary. And details of dress, food and recreation were rigidly prescribed with appropriate penalties for infraction of rules. I suspect that many nurses leaving the hospital field and many prospective nursing students feel that we haven't got far enough away from the medieval idea of the nurse's life quite yet. Until we do, the problem will remain.

Consider also that "the public" means the fathers and mothers and friends who will point to nursing as either an honored, much respected and desired profession or the life of an underpaid, overworked drudge. Each individual hospital in its public relations program should seek to find ways of building a happy, satisfied, cheerful nursing staff. Its ultimate effect on the patient and public good will, not to mention nurse recruitment, will yield rich dividends.

Of course, this is a difficult and many sided problem. Yet its effects are too far reaching to permit such makeshift solutions as maintaining the old order with a dash of practical nurses and volunteer aides. There is a large place for the practical nurse and the volunteer, but they are not the solution to the essential problem of an adequate supply of professional nurses. Moreover, the supply of practical nurses may not prove large unless they are treated wisely.

It is a short step from nurses to the overall employe relations of the hospital. For here, too, is another opportunity for the hospital administrator to exercise wisdom of action that will make the hospital grow in stature in the eyes of employes and public alike.

Interwoven with all these problems, of course, is the great problem of mounting costs. In the course of making long overdue changes, these costs are bound to increase even more. This is cause for concern because it will reflect in higher rates. The hospital and the public must face this inevitable trend together. Can the hospital, working with Blue Cross, find the means of breaking the news, so to speak, to its public? Can it spot those opportunities where it can effectively tell its story to the community?

In these days when wealthy individuals do not bequeath large gifts with the frequency of the past, the trend must be toward seeking support from the entire community. The fund raising campaign can be an excellent opportunity for the hospital to outline its problems, as well as to present its accomplishments and hopes to the people.

This is the first of two articles by Mr. Rich on public relations opportunities for hospitals. The second will appear in the August issue.

Soliloquy of a Syringe

Today if you're ill you may get a pill,
Although I emphatically doubt it.
From hiccups to cancer, a hypo's the answer;
No doctor is ever without it.
Colitis, mastitis, acute hepatitis,
There's never a cause for alarm.
Though your trouble's obscure, still, the remedy's sure;
"We will give him a shot in the arm!"

What has me confused is the language that's used:
A "shot in the arm's" what they mention.
Yet in practice I find that they have in their mind
A totally different intention.
When they smiling appear and with hypo draw near,
I turn up my sleeve on the double.
But that's not the place—I get rolled on my face
And stuck in the seat of my trouble.

Glucose, pituitrin, vitamins, insulin,
Serums and salines and such;
Even things unsuspected are neatly injected,
With equally dexterous touch.
Into muscle and vein, fluids fancy and plain:
They shoot 'em all in in a swarm.
But when they prescribe 'em, why DO they describe 'em
As being a "shot in the arm"?

—J. R. Westervelt

Two Hospital Systems Are Too Many

A projected combination of the voluntary and the tax supported hospitals would provide adequate care for the entire community

ARTHUR J. WILL
Superintendent of Charities
Los Angeles County, California

THE people of California have set up two definite and distinct hospital systems, one for the care of the pay patient and the other for the indigent patient. In this situation there is the implication that the care of patients in county hospitals is probably not as good as that offered in voluntary hospitals.

This is an unfortunate circumstance, if it is true, and while I would be the last to admit that it is true, it seems to me that such a philosophy is entirely wrong and does not reflect credit on the medical and hospital professions or, for that matter, on the thinking of the general public. It is my belief that, outside of a few specialty hospitals, the care given in most of the county hospitals in California is as good as the average care given in most of the voluntary hospitals and much better than that offered in many.

Will Bring Undesirable Result

The continuation of this shortsighted philosophy of two hospital systems for the care of two classes of patients, unnaturally and empirically divided, will eventually bring about the very situation which voluntary hospital people do not want, namely, state hospitalization, by their very refusal to provide for the ever growing mass of patients who, in their extremity, must go to county hospitals.

Condensed from a paper presented at the Association of California Hospitals meeting, 1947.

The Federal Hospital Construction Act, which was largely influenced by the American Hospital Association and the Federal Hospital Commission, looks at a hospital as a community facility, the need for which has been demonstrated by the citizens of that community. The attitude is taken that it is senseless to develop two hospitals where one will serve. Such a situation now exists in certain locations in California where there are perfectly adequate county hospitals which, because of the stubbornness of various people, are reserved solely for the poor. No provision is made in them for the ordinary and proper practice of medicine for the general public in that community.

While it is true that during the last six or seven years there has been no necessity to enlarge county hospitals for the care of the poor, there will again come a time when such a condition will obtain and if the same system that now exists in this state exists at that time, it will become necessary during a depression, when the taxpayers can so ill afford it, to build additional county hospital facilities.

On the other hand, the state law provides that the county boards of supervisors may care for the indigent sick and dependent poor by means of contractual arangements at agreed upon rates between the county authorities and a voluntary hospital maintaining proper standards and then and there doing business within the community, or for that matter, any place within the state. This is thoroughly set forth in the law and while it is subject to legal interpretation by county or district attorneys, it would be a fairly rigid and narrow legal point of view that could not overcome the slight difficulties found to exist in Sections 200, 201 and 202 of the welfare and institutions code of the state.

By a contrary arrangement within the law of California, it is provided that county hospitals may care for pay patients upon the proper payment of suitable charges covering the entire cost of their care and that when, as at present, voluntary hospitals are filled, county hospitals certainly not only can but should accept pay patients.

Represent Small Percentage

Under such a program as we have had in the past, it has been necessary for us to maintain a set of hospitals for the care of those who can pay during good times and another set of good hospitals to care for the poor. Under the most difficult of conditions, the indigent poor of the state represent only about 15 or 16 per cent of the total population, which is to say that only 15 or 16 per cent of the total population would be eligible for public charity.

Nevertheless county hospitals, by and large, throughout California, except in one principal metropolitan area, provide care for about 35 or 40 per cent of the entire population, which is entirely out of line with the percentage of population they should serve. This means that the indigent poor receive far more extensive and better care than do those who can afford to pay a reasonable amount for it.

It, therefore, seems to me that any development of hospitals within the state should be contemplated on the basis of total overall inclusion of hospital beds, and that every hospital bed in a community should be considered a community facility and should be used as such in its broadest sense; that only the number of hospital beds actually needed should be built; that probably only one

system of hospitals should be set up to provide this care and most of the new hospital developments should be voluntary; that these hospitals in their operation should be considered community facilities and be expected to provide care not only for pay patients but for the indigent for whom care would be provided and the bills paid by the county at established rates agreed upon by the local boards of supervisors and those hospitals.

Obviously, under such a program, we should not find ourselves in the position that in bad times the voluntary hospitals would be only 35 to 50 per cent occupied as they often have been in the past, because during periods of depressed financial conditions the county would be paying for those patients who, because of unemployment, had become eligible for county care. And in good times the excess of pay patients would be cared for by the county hospitals.

County hospitals should be licensed. They should be considered exactly the same as voluntary hospitals, *i.e.* as community facilities. County hospital staffs should be organized on the same basis as are voluntary hospital staffs. County hospitals should be used for medical and nursing education the same as voluntary hospitals are used for these purposes. They should be decentralized in exactly the same manner as we plan to decentralize voluntary hospitals.

Would Cut Capital Expense

Thus, by the use of an overall single hospital plan which would incorporate all types and kinds of hospital beds, we should save the complete capital expenditure for the development of at least one set of hospitals. Last, but not least, the philosophy of the people of California should be similar to that of the Congress of the United States when Public Law 725 was enacted to the effect that the money to be appropriated by the federal government should be used for the provision of hospital facilities in communities that need them regardless of whether those were fully tax supported or purely voluntary projects.

Recognizing that a voluntary hospital in California is actually a nonprofit institution, insofar as we think of profit as a motive in private business, the people of California should enact a constitutional amendment which would permit the extension of state funds to equal the extension of federal funds for the development of health and educational institutions.

To sum up, this program does not contemplate the extension of the county hospital system or, for that matter, the extension of the present voluntary hospital system, but is a projected combination of both into the field of voluntary hospital development. The operation of such hospitals should be the joint endeavor of the entire community, including both the public tax supported group and private citizen group.

Thus, with a minimum expenditure for capital projects, a single hospital system would provide adequate hospitalization for all the citizens of the community without loss to private enterprise or loss of independence or dignity to the individual served.

We Can Still Make Use of Male Volunteers

OSCAR SCHNEIDENBACH
Director, Lutheran Hospital, Brooklyn, N. Y.

AMONG the unsung heroes of the war were hundreds of male volunteers who served faithfully and steadfastly in civilian hospitals. This loyal little army of hospital volunteers helped doctors and nurses to maintain civilian health during the critical war years. Expanded use of male volunteers may offer hospitals some relief from pressing personnel shortages today.

The Red Cross male volunteer units serving in the New York area have now officially come to an end. However, a review of the program may show how this service could be adapted to present hospital needs.

Seven hospitals actively participated in the program in the New York City area, three voluntary hospitals and four municipal institutions. For the initial training program each volunteer was required to pass both the standard and advanced first aid courses. Each man was placed under the supervision of the hospital administrator or medical superintendent.

Since these men were never called upon to perform the disaster duties for which they were organized, most of the hospital administrators utilized their services for other functions. Some of the hospitals used as many as from 80 to 100 men, divided in such a way that at least one or two were on hospital duty all the time. To maintain the organization at a high level of enthusiasm, meetings were held at least once a week at most of the hospitals, where group directors arranged interesting programs of lectures and movies.

Many and Varied Duties

The authorized duties of male volunteers in hospitals included: (1) assisting on routine ambulance calls; (2) assisting with registry of patients entering the hospital; (3) assisting the physician in the emergency room with preparation of dressings and splints; (4) holding the patient and assisting the physician while he treated emergency room patients; (5) transporting patients by cart or wheel chair to x-ray room, wards, operating room and other departments; (6) setting up oxygen equipment and apparatus; (7) assisting with the preoperative preparation of patients; (8) assisting in cast room while the doctor applied plaster casts; (9) assisting with erection of fracture frames, fracture beds and apparatus.

Since hospitals are still faced with a personnel shortage, farsighted administrators might well consider the use of similar volunteer units. It must be remembered, however, that a volunteer program is not planned to replace the services of paid nonprofessional people but rather to provide supplementary help for basic hospital services.

ABOUT PEOPLE

Administrators



Ralph M. Hueston has been named administrator of Wesley Memorial Hospital, Chicago, the board of trustees announced on June 20. Mr. Hueston, who will take over one of the most important hospital administrative positions in the country, has been superintendent of the Hurley Hospital, Flint, Mich., a 485 bed institution, for the last twelve years. Before going to Michigan he was superintendent of the Silver Cross Hospital, Joliet, Ill., for ten years.

Now 53 years old, Mr. Hueston was born and educated in Iowa. He entered the hospital field in 1924 as superintendent of Cottage Hospital, Galesburg, Ill. He is a fellow of the American College of Hospital Administrators, past president of the Michigan Hospital Association, delegate from Michigan to the American Hospital Association and was organizer and president of the Flint Hospital Council. He was chairman of the hospital survey committee for Michigan and has been a member of the board of trustees of Michigan's Blue Cross, which he helped to organize in 1938. He is also a trustee of the Michigan Medical Service, the statewide medical service plan.

At Wesley Hospital Mr. Hueston will succeed the late **Edgar Blake Jr.,** who died last March. Mr. Blake had been administrator at Wesley since 1941.

Leon N. Hickernell, administrator of the University of Georgia Hospital, Augusta, Ga., has been named to succeed **Dr. A. K. Haywood** as head of Vancouver General Hospital, Vancouver, B. C. Prior to going to the University Hospital, Mr. Hickernell had been assistant superintendent of Cleveland City Hospital and of New Haven Hospital, New Haven, Conn.

Charles E. Findlay has resigned the post of administrator of Wyandotte General Hospital, Wyandotte, Mich., to accept a similar position at Alpena General Hospital, Alpena, Mich.

Mrs. Walter P. Warren, administrator of Samaritan Hospital, Troy, N. Y., has submitted her resignation to take effect on September 1. Mrs. Warren will become director of social activities at Rensalaer Polytechnic Institute at Troy. At the same time announcement was made of the resignation of **Jay W. Collins,** as assistant administrator. Mr. Collins has accepted the position of superintendent at Glenville Hospital, Cleveland.



Dr. Stanhope Bayne-Jones, professor of bacteriology, Yale University School of Medicine, and director of the board of scientific advisers of the Jane Coffin Childs Memorial Fund for Medical Research, has been appointed first president of the joint administrative board of New York Hospital-Cornell Medical Center, New York City.

Blair M. Patterson, administrator of Elyria Memorial Hospital and Gates Hospital for Crippled Children, Elyria, Ohio, has resigned to accept a position with Continental Hospital Service, Inc., Cleveland. Mr. Patterson entered the field of hospital administration in 1927, serving ten years in New York City and three years in Bridgeport, Conn., prior to going to Elyria in 1940. He served three and a half years in the medical administrative corps of the army.

May A. Middleton has resigned as head of Methodist Episcopal Hospital, Philadelphia, after thirty-three years of service with the institution, most of that time in the capacity of superintendent. During her association with the hospital, Miss Middleton has been very active in hospital organization affairs in Philadelphia and Pennsylvania, serving as president of the Philadelphia Hospital Association and vice president of the Hospital Association of Pennsylvania. **Rev. Frank Prentzel,** formerly superintendent of the Northwest District of the Philadelphia Methodist Conference, succeeds Miss Middleton.

Earl F. Mitchell, former administrator of Lockport City Hospital, Lockport, N. Y., has resigned to become head of Elizabeth A. Horton Memorial Hospital at Middletown, N. Y., succeeding **Dr. Arthur S. Moore. Joseph Blaha** will take over Mr. Mitchell's position at Lockport.



Dr. J. Gilbert Turner, whose appointment as administrator of the Royal Victoria Hospital, Montreal, was announced in these pages in June.

Dr. W. A. Rohlfing is now the medical director of Fresno County General Hospital, Fresno, Calif.

Robert B. Witham, administrator of Lincoln General Hospital, Lincoln, Neb., has resigned to join the staff of the United States Public Health Service, with headquarters in San Francisco. His successor is **T. J. McGinty,** formerly of City Hospital, Brunswick, Ga. Mr. Witham went to Lincoln in 1943 after serving as special assistant to the commanding general at Fitzsimons General Hospital, Denver. He recently completed twenty-five years in hospital administration and is a fellow of the American College of Hospital Administrators.

Donald C. Carner has been named assistant administrator of Northwestern Hospital, Minneapolis.



Charles S. Aston Jr. has been named manager of the recently reorganized Covina Hospital, Covina, Calif. The institution was purchased by the hospital trustees from the Misses Melisse and Mary Wittler, who opened it in 1922, and incorporated on an intercommunity nonprofit basis. Mr. Aston, who was director of Tucson Medical Center, Tucson, Ariz., from 1944 to 1946, has recently completed work with the staff of James A. Hamilton and Associates in making the Los Angeles Countywide Hospital Survey.

James McKelvey Jr., a member of the course in hospital administration at Northwestern University, Chicago, has been named administrative intern at East Orange General Hospital, East Orange, N. J.

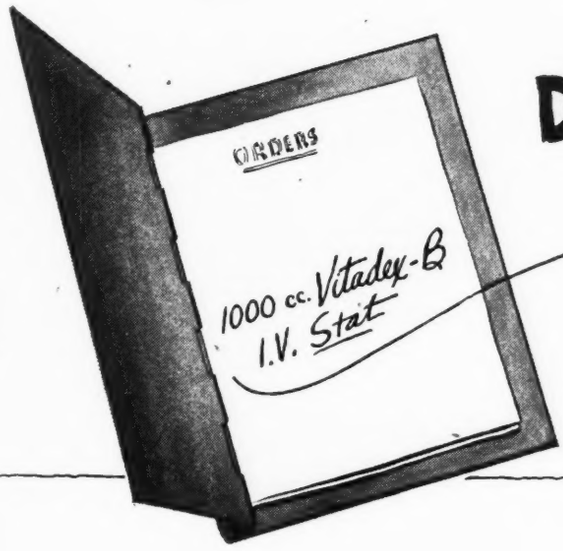
Dr. Donald M. Morrill has resigned as administrator of Mount Vernon Hospital, Mount Vernon, N. Y., it has been announced by **Harold B. Storms,** president of the board of trustees. At the same time, announcement was made of the resignation of **Mrs. Madolin W.**

(*Continued on Page* 160.)



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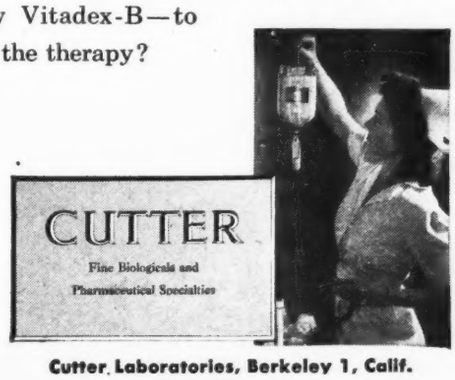
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*Sebrell, W. H., Jr., et al: J. Pediat. 22: 494-507, April, 1943.

TRUSTEE FORUM

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Audits Measure Our Results

GEORGE GRAY WARD, M.D.
Chief Surgeon Emeritus
Woman's Hospital
New York City

THE governors or trustees of a hospital are primarily responsible for the kind of care and treatment that the patient receives, as well as for the fulfillment of the other functions of the hospital. They should not lose sight of the fact that the hospital which most successfully fulfills its functions is the one that is conducted with the primary ideal of procuring for the patient the best professional care and not from the business standpoint of financial surplus. Hospital governors, as a rule, do not give the same intensive study to their hospital problems that they do to their individual businesses. They are interested principally in the balance sheet and do not concern themselves as to whether the results of the treatment the patients receive are what they should be. They presume they are but they do not know the actual facts.

Too Many Are Boarding Houses

Because a hospital has socially prominent trustees and large elaborate buildings with beautiful surroundings, it does not follow that the patients of that hospital receive the skillful treatment they have a right to expect. As has been well said, many such elaborate institutions are mere boarding houses or hotels for the sick. We all know that a small hospital situated in the country may give the highest type of scientific service to its patients.

The product of the hospital is health, and no hospital can be better than its medical staff. We know that it is the character of the medical staff that determines the product of the hospital, and the governors, or trustees, determine the type of the medical staff. A man who accepts a position on the governing board of a hospital should realize that he accepts a public trust and that hospital trustees stand in the same relation to a hospital as business trustees do to a trust fund. Therefore, they should demand and see that they get efficient results for the money they expend. Their responsibility can only be fulfilled when they have provided a conscientious, efficient medical staff and a competent, tactful superintendent.

It is the duty of the profession to educate the trustees as to their responsibilities, and when we can show them that efficiency in the hospital, as in the factory, is an economic problem they will become interested.

Bancroft's statement that "every cured and satisfied patient leaving the hospital is an asset, and every unimproved or dissatisfied patient is a liability" is just as true in the medical world as is its counterpart in the business world.

This all implies that an annual systematic analysis of results must be made from accurate history records and the end results must be studied and audited.

Codman of Boston in 1913 awakened the profession to the importance of an audit in his advocacy of an "End Result System" for hospitals.

The usual annual report issued by hospitals which shows the number of patients treated and the number of operations performed may indicate the volume of work done, but it does not show the character of the work done or the results obtained. As we well know, the term "recovered" too often means recovered from the operation and not recovered from the disease.

The end result system of Codman requires that the records of the hospital should answer the following questions for each patient: What was the matter with the patient? What did the doctor do for him? What was the result? If the result was not good what was the reason? Was it the fault of the doctor, the disease, the hospital organization or equipment or the patient?

The Swedish government requires an annual report from every hospital in the land, which is a real audit, showing not only the quantity of work done but also the quality of the work and by whom it was performed. In other words, in Sweden the government demands an official accounting from all its hospitals of the manner in which they care for those in their charge, and it includes the individual record of the personnel. The reports demand data that show the exact dates of service and the quality of the work of each member of the staff.

Results Must Be Shown

It is obvious that in order to promote efficiency, the actual results accomplished by each surgeon or physician in the care and treatment of the cases placed in his charge must be made available for study; hence, the absolute necessity of a production sheet for the hospital as for the industrial plant. Reports should be presented to the trustees in order that they may know what sort of product the hospital is producing and whether they are getting an adequate return for the funds which they are expending in the interest of its benefactors and the public. The time is not far distant

From a paper read before the New York Academy of Medicine, April 1947.





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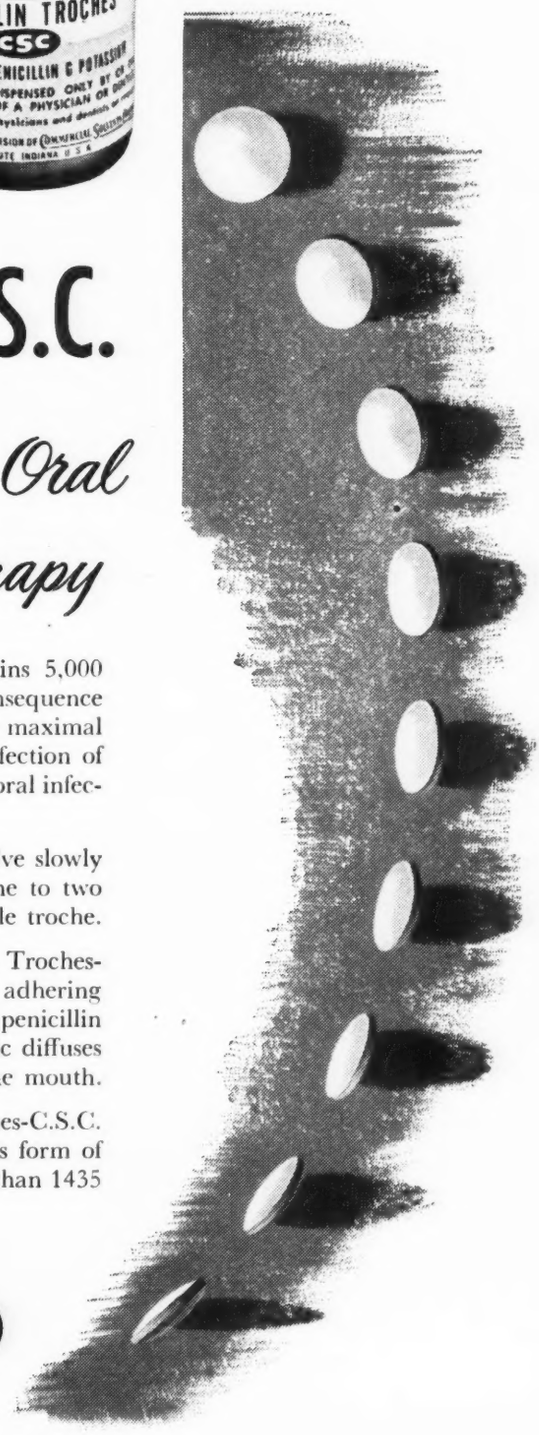
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when the trustees of a hospital will not be able to ask for public support without giving assurances to the people of the community that the product of the hospital is what it should be.

It is the responsibility of trustees to know the mortality and infection rates of their hospital, also the mortality and morbidity results and the percentage of successes, partial successes and failures of each member of the staff.

This requires that a systematic audit be made each year from properly kept records. The importance of this work requires that expert assistance be employed, such as can be given only by one trained as a professional statistician.

Professional Audit Made

In the Woman's Hospital in New York we have attempted to solve our particular problem by establishing such an audit, and for the last twenty-five years such an accountant's audit has been made each year by professional statisticians and a report has been rendered which is illustrated with colored graphs and the associated figures. We were fortunate in having the aid of the late Frederick L. Hoffman, dean of vital statisticians, in guiding our efforts in this pioneer work, which was most helpful. We had to feel our way, sometimes retracing our steps and exploring new paths of procedure.

We sought to determine not only the general death rate for the hospital to afford a basis of comparison with other hospitals of a similar type, but the death rate and morbidity rate of the several divisions and the individual surgeons, so as to serve as a guide for future executive policies. We also studied the healing of sutured wounds, clean and infected cases, in order to show the percentages of primary union and infection of each operator.

Our experience with the employment of a professional statistician to audit our surgical results has confirmed most positively our opinion that it not only is a great advantage in facilitating the compilation of our statistics, but is an essential warranted by the great importance of a serious problem. This study has shown that the usual methods employed by hospitals in compiling their statistics of mortality and morbidity without proper qualifications and definitions are practically valueless for comparative purposes.

No one will dispute the value of a chartered accountant to audit the funds entrusted to an institution. Is there not the same need for a medical accountant to audit the work of an institution in which we are dealing with human lives and health as there is in the case of our dollars? He is necessary not only to evaluate properly the general mortality results of hospital care but to study the mortality and morbidity rates of the personnel of the staff and of the methods of treatment employed in the various diseases and conditions cared for.

At the end of the period of observation all cases are classified as successes or failures, and this classification is not based upon the anatomical result of the operation or treatment, but upon whether the patient was cured of the complaints for which he sought relief.

A continuing oversight is thus provided by which the work of the hospital and the activities of the individual members of the staff can be evaluated from year to year.

These end result studies are of great value to the patient, to the physician and surgeon and to the hospital. For the patient, the mortality and morbidity are reduced; for the doctor, his illusions are dispelled, and for the hospital, greater economy is accomplished.

The economic value of end result study is incontrovertible. The doctor becomes more proficient and is stimulated to greater efforts and to the correction of faults. The days saved to the patient and the hospital by speedier convalescence means money saved to both patient and hospital.

As soon as the trustees of our hospitals appreciate that, as a rule, they have no accurate knowledge of the character of the work being done and they cannot have such knowledge unless a systematic study of end results is carried out on the lines followed in industrial plants where the production sheet shows facts, not suppositions, they will demand such a public accounting. And if it falls short of what they have a right to expect of the hospital and its staff they will insist upon the necessary reorganization to make the institution efficient.

VOLUNTEER ACTIVITIES

The Auxiliary Took Over

The pharmacist at Nassau Hospital, Mineola, N. Y., prepared an attractive exhibit of pharmaceuticals in connection with National Pharmacy Week and it was displayed in the window at a local bank in Mineola, N. Y. But the exhibit needed attendants to answer questions and take charge of the display. Nobody on the hospital staff could spare the time so, naturally, the women's auxiliary took over.

Patty Plays for Scholarship

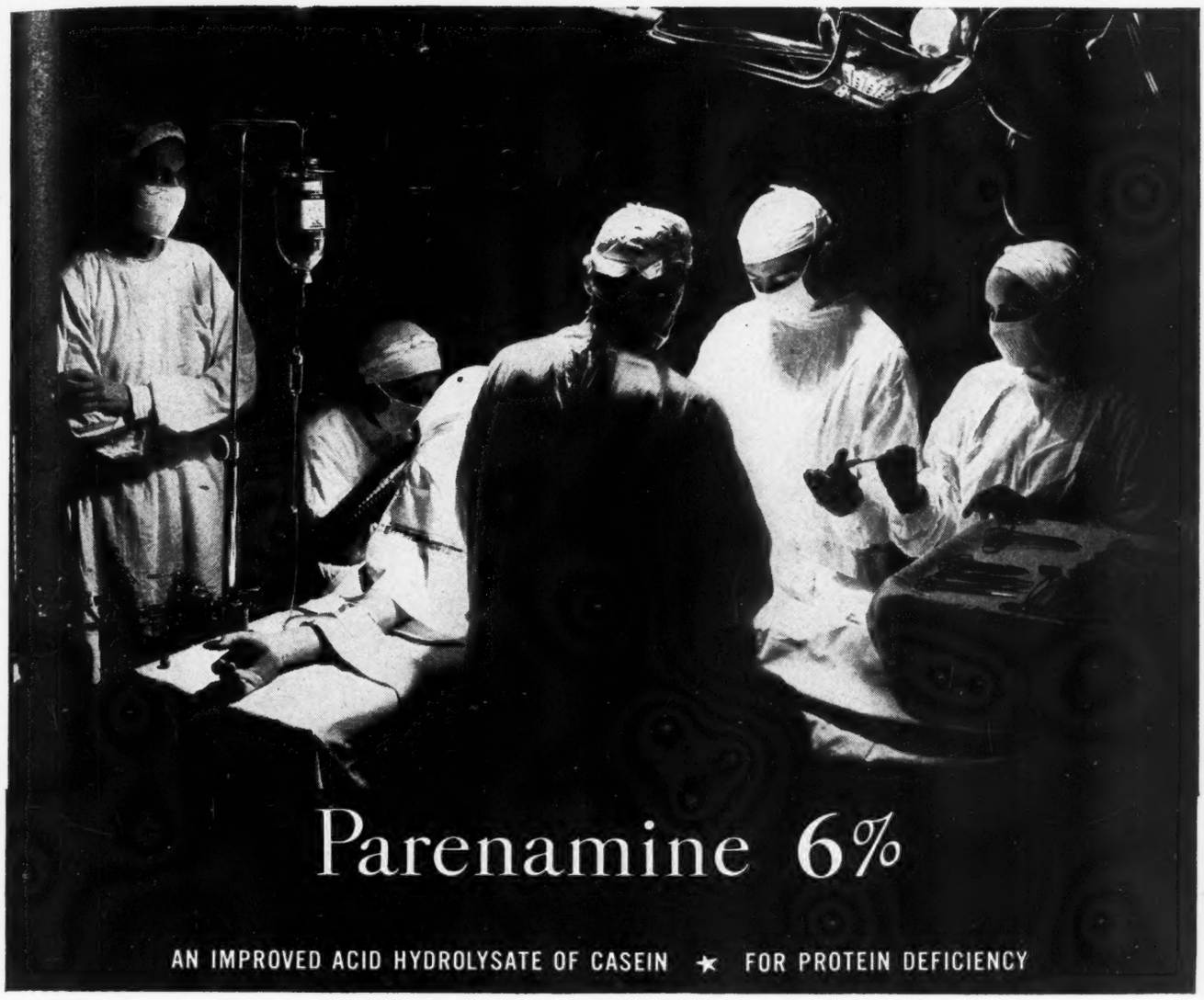
An exhibition golf match recently benefited the nurses' scholarship fund at Middlesex Hospital, Middletown, Conn. Sponsored by the hospital auxiliary, the match, despite cold and wet weather, drew a large crowd. Patty Berg, National Open golf champion, was the featured player, teaming up with a Connecticut player to meet and defeat two home club players. It was a nine hole exhibition game and was followed by a supper.

Two auxiliary members also interested the Essex Women's Club in sponsoring a Middlesex Hospital Night at which student nurses gave a skit and an "Information Please" program was presented with the board of experts consisting of the president of the board of directors, the director of nurses, the dietitian and the controller, with Howard Pfirman, administrator, serving as mediator.

From Volunteer to Pay Roll

A wheel chair patient for fourteen years, he could not find the right job but thought there might be some task he could perform as a hospital volunteer. This handicapped man presented himself to Evanston Hospital, Evanston, Ill., not long ago and asked to be fitted into the volunteer program.

The hospital administrator himself interviewed the wheel chair volunteer and found that photography is his hobby. Now Evanston Hospital has a full time photographer and he isn't a volunteer; he's on the pay roll.



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The Value of Internship as the Intern Sees It

This letter was received from a young physician following the appearance of an article on the internship program in a recent issue of The MODERN HOSPITAL. Because it offers some food for thought for hospitals and leaders in the hospital and medical education fields, we have obtained permission of the author to present it. For obvious reasons, he has asked that his name be withheld.—THE EDITORS.

I HAVE just finished reading the article, "Never Underestimate the Value of Internship," which appeared recently in The MODERN HOSPITAL, and I feel I must take exception to some of the statements in it.

I hope that perhaps my remarks will contribute to an understanding of the internship from the point of view of one who has recently undergone the rather disquieting experience of choosing, being accepted for and serving an internship.

The article states: "I am quite convinced that the stipend offered hardly enters the good student's mind and that he does not seek out the hospital that pays the most." Perhaps I cannot qualify for the classification of "a good student" but I feel quite secure when I say that the question of stipend does enter the mind of the average student. And the average student makes up most of every graduating class. The salary may not be a decisive factor in his choice but it is certainly considered.

A medical education is a long and expensive process. The present trend is to lengthen rather than to shorten that process. Many excellent students are prevented from entering the profession because of that cost. Many others are forced to engage in outside work or borrow in order to complete their education.

The medical school graduate when he seeks an internship is a product of seven years of specialized education and has invested between $7000 and $10,000. His earning power is roughly from $50 to $75 a month. Granted that a period of internship is a necessary part of his training, that it represents a continuance of his education, the fact remains that the hospital obtains his services for a pittance. And his services to the hospital are by no means negligible. He is for the first time a contributor; his contribution represents $7000 to $10,000 worth of education, working seventy or more hours a week. I should like to advocate, and to see the A.M.A. sponsor, a minimum salary of $150 a month for interns.

Would Have to Improve

The article deplores the practice of hospitals competing for interns on a salary basis but offers no practical solution. Would it not be preferable to remove the economic pressure on the intern and give him an opportunity for a free choice on the basis of the quality of the internship? If this were done the hospitals that have been substituting money for quality would be forced to improve their internships.

The hospitals would be repaid by the attitude of the intern toward the hospital which would be expressed in his work. He would cease to regard it as an impersonal organization concerned only with getting something for nothing.

In my graduating class in 1944, 48 per cent of the class were married. The normal expectation of married graduates was formerly in the neighborhood of from 10 to 15 per cent. The difference was due largely to the salary they received as members of the armed forces.

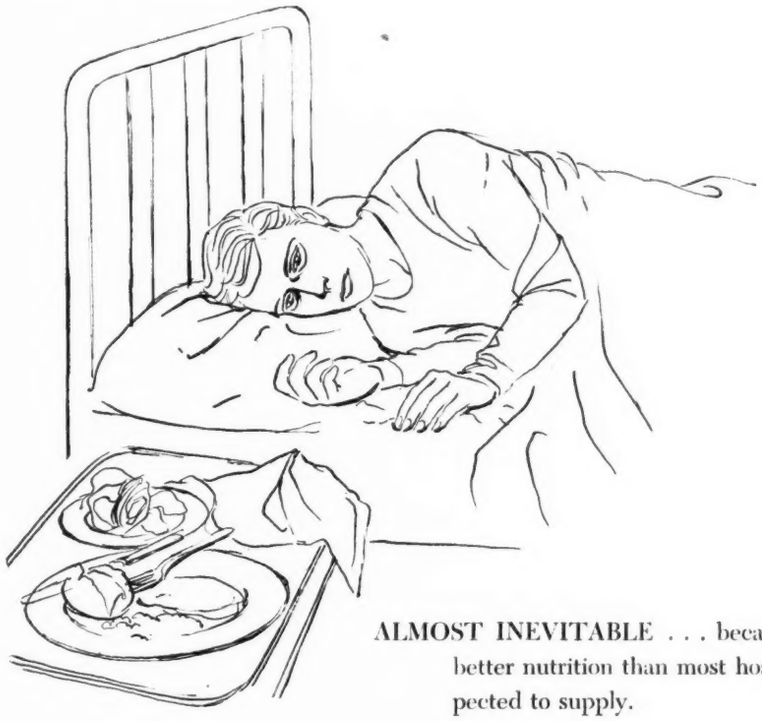
The same married students upon graduation were, of course, faced with the necessity of continuing the support of their families. This necessitated a compromise between quality and salary when they chose an internship. They recognized that they were in many cases sacrificing quality, but at the same time they recognized that any nine month internship was inadequate and most of them planned to resume their training after their separation from the service. They were encouraged in this by the statements of the Council on Medical Education and Hospitals which assured them that the facilities would be adequate to meet their needs, a statement which, as is admitted in the article, is not substantiated by the facts.

Why should the young men seeking to enter the medical profession be unduly penalized? It is commonly recognized there are not enough physicians in this country to give adequate care. The legislation before Congress is an expression of the dissatisfaction the people feel concerning the care they receive.

Would it not be wiser for us to make it as easy as possible for the student who is attracted to medicine? I certainly do not favor subsidizing the medical student but I do believe in paying him a salary commensurate with his services.

The A.M.A. possesses the ability to assure the intern that the hospital he chooses will provide him a good internship, and it is the duty of the A.M.A. to see that the internship *is* adequate. No fourth year medical student seriously considers a hospital for internship that is not approved by the A.M.A., no matter what the salary offered. And yet, there is so much difference between hospital A and hospital B, both approved, that while one can get interns for a salary of $15 a month, the other is forced to offer $165 a month.

This difference in salary represents a difference in quality — yet both are A.M.A. approved—an approval which is supposed to measure quality. Would it not be better to raise the standards for A.M.A. approval? This certainly would remove from the list the least qualified hospitals, the ones that have been the keenest competitors as far as salary



Some degree of nutritive inadequacy is almost inevitable in patients on standard hospital diets

ALMOST INEVITABLE . . . because sick patients require better nutrition than most hospitals are commonly expected to supply.

ALMOST INEVITABLE . . . because even if the full diet is supplied it cannot always be consumed.

ALMOST INEVITABLE . . . because, even assuming the patient is in normal nutritional balance upon admission to the hospital (which he probably isn't) "infections and injuries (and the latter include major surgical operations) produce rapid wastage of protein tissues and of stores of vitamins and minerals."[1]

"Recently . . . nutrition has been found so important in the recovery of patients with various 'surgical' diseases that the surgeon himself has been forced to pay more and more attention to the diets and dietary supplements, such as vitamins, that are given his patients."[1]

1. Editorial: J. A. M. A. **134**:292 (May 17) 1947.

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is concerned, and it would also assure the intern of an adequate internship.

Raise the standards and insist that they remain at a high level by frequent inspections. At present, A.M.A. approval is often a matter of paying lip service to the rules until the approval is obtained and then forgetting the whole matter. Coercion is not a nice word, but I think the A.M.A. has the responsibility for maintaining the standards of medical education and medical care, and if coercion is necessary, let us use it.

I also object to the term "fifth year medical student." Granted, they do not know much, but at least allow them the dignity and respect of the title of "intern." As I have previously pointed out, they are not wholly parasitic during their internship; they are not only students, they are contributors as well.

In many instances they contribute a great deal more to the welfare of a patient than does the attending physician, whose esteemed position and vaunted knowledge are too often the result of his age, appearance and ability to convince the public, instead of being based on his ability to practice medicine. Let us at least accord the intern more than the status of a student.

No Personal Bitterness

In spite of the way I have expressed myself, this is not a case of personal bitterness. I was fortunate enough to get what I consider a good nine month internship and I have been accepted for a residency. Many of my classmates have not been so fortunate. Neither is this entirely a reflection on the article, but it is an expression of my resentment of the treatment accorded interns, which is clearly reflected by it.

It seems to me that the A.M.A. underestimates the value of the intern. I believe the Council on Medical Education and Hospitals has, in the main, done an excellent job, but I do not believe it has done as much as could and should be done. I am a firm believer in orderly evolutionary processes and the policy of watchful guidance, but there are times when that policy is not sufficient. It is not *always* the best policy. Even during evolutionary change action is occasionally indicated and necessary.

The A.M.A. has been consistently criticized as being a reactionary group, apparently with justice in many cases if we can judge by the times when it has belatedly reversed its stand on many matters during the past several years. Speaking as a younger member, I say let us not forever deserve that criticism. We must learn to meet change.

As a group we are too much committed to a policy of laissez faire, too much like the proverbial ostrich with his head in the sand. The attempt to repress an evolutionary change only results in increasing the violence of the change when it does occur.

The older men of the A.M.A. who are largely responsible for our policies may well be reluctant to endorse any change. Because of their successful past and enviable present they may feel justified in trying to preserve the status quo, hoping the change will not come to pass during their lifetime. We, as younger members, do not have that solace and we can look forward only to meeting the changes and adjusting ourselves to them.

Help us do it as smoothly and gracefully as possible by recognizing an evolutionary process in the making and guiding it into conformity with our own desires and plans.

This letter expresses my own point of view, which is, I assure you, similar to that of many of the younger members of the profession.

NOTES AND ABSTRACTS

Prepared by the Committee on Pharmacy and Therapeutics, University of Illinois College of Medicine, Chicago 12

Anticonvulsant and Anti-Epileptic Drugs

A CONVULSION is unquestionably the body's most awe-inspiring means of manifesting disordered function. Convulsions may occur in a great variety of conditions, including head injuries, brain tumors, drug intoxications, acute febrile diseases, anoxia, uremia, eclampsia and during ether anesthesia. Such convulsions will usually cease if the cause can be corrected and, in the meantime, they can be controlled by the administration of adequate amounts of most central nervous system depressants. Short acting soluble barbiturates, given carefully by vein, are generally the drugs of choice.

Considerably more of a problem, and of more far reaching, life-long significance to the individual, are the repeated seizures, convulsive and otherwise, associated with epilepsy. The unfortunate consequences of this condition reach into every field of life, often making normal attitudes and normal activities impossible for the untreated sufferer, who may otherwise be a normal, healthy individual. In addition, the high incidence of epilepsy places this disorder in a class with diabetes and tuberculosis as a medical problem.

Epilepsy is as old as mankind, and in every age remedies have been sought. Unfortunately, the fantastic concoctions of one era always proved as useless as the incantations of another; and the medical profession had little better to offer until less than 100 years ago.

While certain cases of epilepsy are caused by demonstrable foci of irritation in the brain—tumors, scars or abscesses that can be treated surgically—the word "idiopathic" displays our essential ignorance both as to the precipitating factor in the vast majority of patients and as to the fundamental biochemical cause. A few patients respond to changes in their regimen of life, to psychotherapy or to such measures as mild dehydration or a ketogenic diet; but the majority, again, must look to drugs for help. Now, fortunately, they do not look in vain. No drug cures epilepsy, but seizures can be controlled in the majority of cases.

Historical: The history of drug treatment of epilepsy begins with the story of the bromides. These were discovered in 1826, in sea water, but their depressant effects on the central nervous system were not recognized

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for some time. It was not until 1857 that they were used in epilepsy by Locock, who had noted their inhibitory effect on sexual function, then believed to have a connection with epilepsy. The introduction of bromides was a tremendous advance, but their sedative effects went hand-in-hand with their anticonvulsant effects to such a degree that the patient, free from seizures, usually was drugged into mental subnormality. The occurrence of chronic intoxication, "bromism," often further marred the therapeutic result.

It was not until 1912 that the specific effect of phenobarbital upon the motor cortex was noted by Hauptman and put to use. This, again, was an advance; and the drug deservedly gained favor. But while chronic intoxication was less of a problem, the sedative effect of the anticonvulsant dosage again often barred the patient from useful work and normal life.

Another long wait preceded the next advance, but this interval was marked by important strides toward better understanding of epilepsy and clearer delineation of its types. Most significant was the development of the electroencephalograph (EEG) and recognition of the brain wave patterns in grand mal, petit mal and various "mixed" forms of the disorder, and of cortical localization in focal and Jacksonian types. It provided a new means for study, for diagnosis and for the evaluation of the effectiveness of drugs.

The importance of accurate diagnosis in epilepsy increased with the introduction of dilantin by Merritt and Putnam in 1938. Here was a brilliant discovery: a drug having great anticonvulsant effect with a minimum of sedation. But its beneficial effects were confined almost entirely to grand mal epilepsy and grand mal components of mixed types; dilantin therapy sometimes aggravated cases of petit mal.

Newer Discoveries: This progress was followed in 1944 by the introduction (by Everett and Richards) of tridione, a drug having remarkable effectiveness in petit mal (as shown by Perlstein and Lennox), again with relatively little sedative effect. This was the first drug to prove really effective in petit mal epilepsy, the type characterized not by convulsions but by momentary episodes of unconsciousness: not just a "mild form of seizure" but a distinct type in itself, as proved by the EEG.

The search for new drugs has continued vigorously. Compounds chemically similar to those of known efficacy have been investigated in the hope of finding drugs with greater effectiveness and fewer undesirable side-effects. One recent introduction, mesantoin, has proved useful in grand mal epilepsy and is sometimes effective when dilantin fails. It is more sedative in action than the latter but does not produce the gum hyperplasia which has plagued some users of dilantin. Another drug, mebaral, in some cases adds to the control of both grand mal and petit mal without producing as much soporific effect as does its chemical sibling, phenobarbital.

Much remains to be done. For example, no drug has proved capable of controlling the weird manifestations of psychomotor epilepsy (the so-called "epileptic equivalents"), although certain combinations of drugs may benefit a minority of patients. Some of the drugs useful in other types only aggravate this form of epilepsy.

Even the best drugs available today have some undesirable effects. Most of them are mild, but some definitely prohibit further use of the drug; and a few, like agranulocytosis seen in rare instances after tridione therapy, have fatal potentialities.

Experimental Methods: The methods employed in studying new anticonvulsant drugs deserve mention. Naturally, all promising drugs must eventually be given clinical trials, used in patients actually suffering from the disease. Before this can be done effectively or safely, however, a drug must have its possible usefulness and safety established by careful animal experimentation. To do this, it is necessary to produce in animals conditions resembling the actual convulsions or EEG changes of the type of epilepsy under consideration. Then the efficacy of drugs against these conditions can be measured.

Passage of an electrical current through the central nervous system of an animal will be followed by a convulsive seizure almost identical with that seen in grand mal. The brain waves of petit mal can be reproduced by the administration of subconvulsant doses of metrazol, a central nervous stimulant, and drugs that will prevent these brain-wave changes (and also metrazol convulsions) are found to be effective against petit mal seizures in man. Unfortunately, no way has been found as yet to simulate epileptic equivalents experimentally.

These experimental technics are utilized in a variety of ways, among which can be mentioned: Determination of the degree to which a drug will:

1. Increase the amount of electricity required to produce convulsions in normal or overhydrated animals ("elevate the electroshock seizure threshold").

Anti-Epileptic Drugs in General Use

Drug	*Daily Dose*	*Use*	*Side Actions*
Dilantin (Parke, Davis and Co.)	0.2-0.6 Gram	Grand Mal	Ataxia, dizziness Hyperplasia of gums Nausea, gastric distress Skin rash*
Mebaral (Winthrop)	0.2-0.4 Gram	Grand Mal Petit Mal	Drowsiness
Mesantoin (Sandoz)	0.2-0.6 Gram	Grand Mal	Skin rashes* Fever Drowsiness
Tridione (Abbott)	1-2 Grams	Petit Mal	Photophobia Dermatitis* Blood dyscrasias*
Phenobarbital (U.S.P.)	0.1-0.2 Gram	Grand Mal	Drowsiness
Na or K Bromide (U.S.P.)	1-5 Grams	Grand Mal	"Bromism"* sluggishness skin rash

* Signs of sensitivity that require prompt discontinuance of drug.



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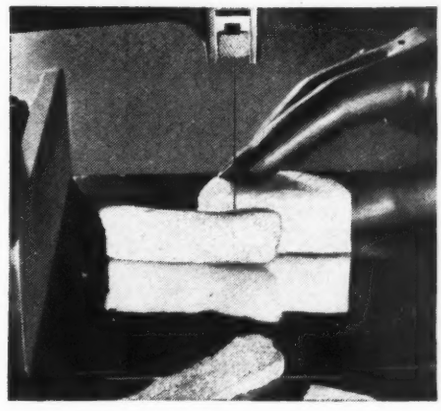
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2. Modify the pattern of grand mal-like electrical convulsions. (Effective drugs will eliminate the tonic phase of the well known tonic-clonic fit.)

3. Increase the amount of metrazol required to produce petit mal-like EEG changes or metrazol convulsions.

In clinical testing on epileptic patients, the following points are given especial attention:

1. Effect of the drug on seizure incidence and character.

2. Signs of toxicity.

3. The effect of withdrawing the drug.

4. Influence of the drug and its withdrawal on the brain-wave pattern of the patient.

5. Efficacy of treatment when combined with other drugs.

Management: While it is not within the scope of this article to provide an actual guide to the treatment of epilepsy, the table on page 94 attempts to summarize the principal facts currently recognized concerning the drugs used. A few general principles might be mentioned:

The first step in the management of a suspected epileptic is an adequate general workup, including history, physical examination and laboratory work. With these data in hand, it will often be possible to rule out other conditions capable of producing a similar picture and to establish, within limits, the type or predominant type of epilepsy present. Since diagnosis is so important, an EEG workup is always advisable when this service is available.

Careful diagnosis will generally lead the physician to the correct drug or drugs to employ, but it must be emphasized that, owing to individual differences and to the tendency of mixed types to occur, each case is essentially a new experiment. It may be necessary to try a variety of agents, alone or in combination, to achieve optimum results. In this connection, one must be cautious in discontinuing one form of therapy before another has taken full effect: for example, in substituting dilantin for phenobarbital in grand mal epilepsy, abrupt cessation of phenobarbital therapy may precipitate status epilepticus, a grave succession of seizures not separated by intervals of consciousness.

Another danger in experimentation (and another argument for accurate diagnosis when possible) lies in the fact that the appropriate medication for one form of epilepsy may aggravate other types. This phenomenon may complicate the therapy of mixed types, occasionally, by activating a latent or secondary component. Sometimes, a suitable medication may tend to alter the type of seizure in a patient, as, for example, when a petit mal sufferer experiences his first grand mal attack under tridione, as has been known to happen. Electroencephalographic studies contribute much to the understanding and prevention of such complications.

When the physician has arrived at an effective form of therapy for a patient, he must then strive to reduce the dose to the minimum amount which will be effective. He must always be alert to observe the development of toxic manifestations (particularly damage to white cells and platelets when tridione is being used) and he must use laboratory methods wherever possible to detect such toxic reactions.

Conclusion: The number of epi-



another of its several advantages:

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in vitro in the presence of such organic matter as blood, serum and bacterial debris[1,2,3], when its minimal antibacterial concentrations are increased as from two to ten times. Results in vivo also demonstrate its effectiveness in the presence of wound exudates[4,5].

Indications

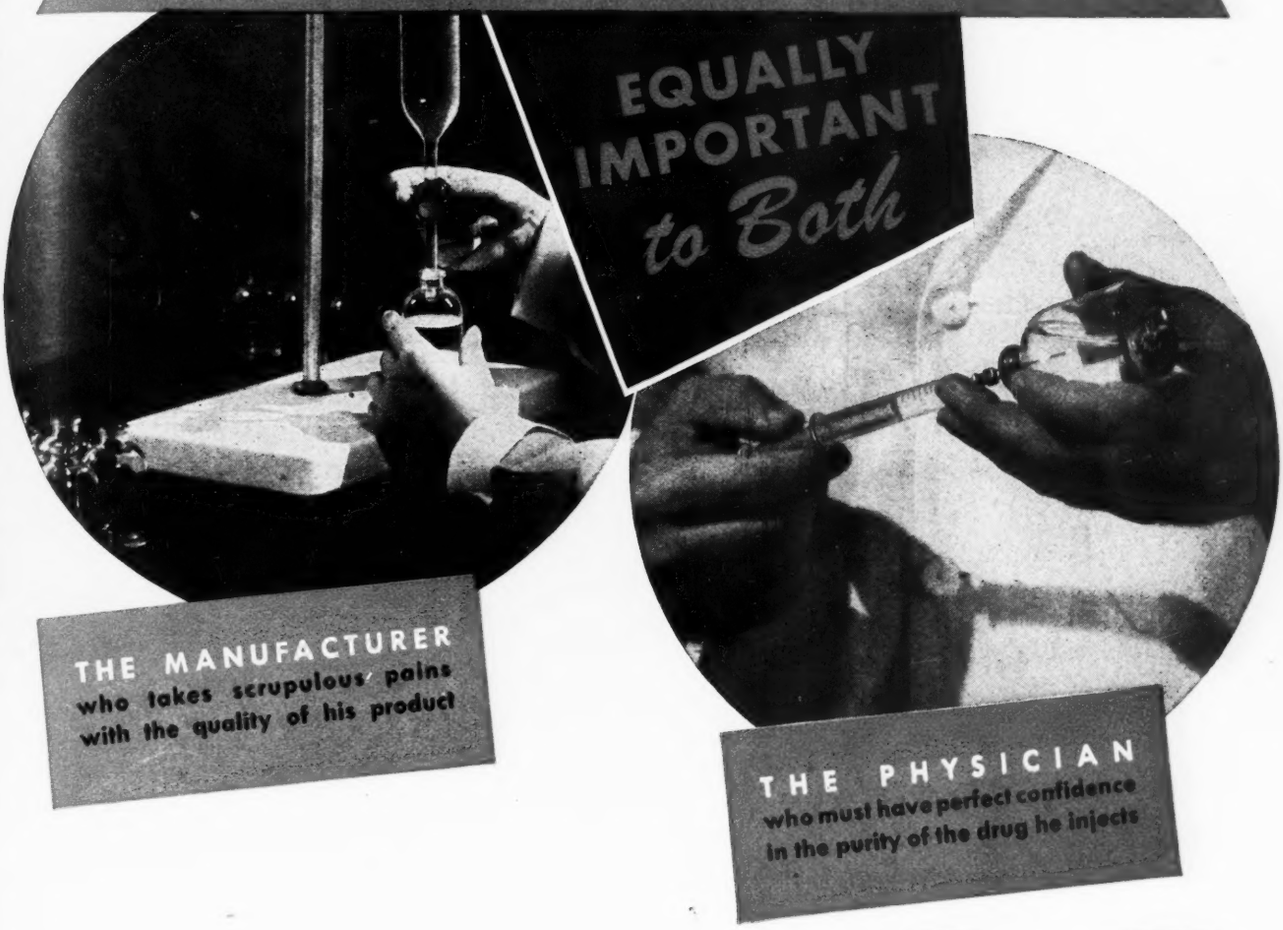
Infected surface wounds, or for the prevention of such infection
Infections of second and third degree burns
Carbuncles and abscesses after surgical intervention
Infected varicose ulcers
Infected superficial ulcers of diabetics
Impetigo of infants and adults
Treatment of skin-graft sites
Osteomyelitis associated with compound fractures
Secondary infections following dermatophytoses

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LITERATURE ON REQUEST

1. Dodd, M. C. & Stillman, W. B.: J. Pharmacol. & Exper. Therap. *82*:11, 1944 • **2.** Cramer, D. L. & Dodd, M. C.: J. Bact. *51*:293, 1946 • **3.** Dodd, M. C.: J. Pharmacol. & Exper. Therap. *86*:311, 1946 • **4.** Neter, E. & Lambarti, T. G.: Am. J. Surg. *72*:246, 1946 • **5.** Snyder, M. L., Kiehn, C. L. & Christopherson, J. W.: Mil. Surg. *97*:380, 1945.

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leptics in the country is so great that there are by no means enough specialists to care for them. It is thus the responsibility of the general practitioner to gain a workable understanding of the problem and of the effective measures he can take to prevent the recurrence of seizures.

It is likewise well for all medical and hospital personnel to realize that since epilepsy is today virtually as controllable as diabetes, they should give encouragement to its victims and guide them to adequate sources of help.—E. H. LANPHIER.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

Rheumatic Fever

The "Need for a Public Health Program in Rheumatic Fever and Rheumatic Heart Disease" is eloquently described by Dr. David D. Rutstein of the New York City Department of Health in the May 1946 number of the *American Journal of Public Health*.

Dr. Rutstein points out that, although rheumatic fever and rheumatic heart disease are the commonest causes of mortality and disability in children and young adults, they have never received the attention they deserve from public health workers. This disease entity ordinarily has its onset in early childhood with frequent recurrent attacks, usually in winter and early spring, until puberty is reached. Rheumatic heart disease with its mutilated heart valves is the scar of acute rheumatic fever.

The prognosis for a victim of this disease is demonstrated in a recent study of 1000 child patients at the Home of the Good Samaritan in Boston. These children were followed for 10 years after the initial attack and it was found that, at the end of that period, approximately 21 per cent had died, 35 per cent were incapacitated to varying degrees and only 44 per cent were able to lead normal lives. Furthermore, it is reasonable to expect that further mortality and disability will occur after the first ten year period.

Death Ratio Is High

In a study made in Philadelphia for the year 1936, the average age at death of individuals suffering from this disease was 36.5 years, as compared with an average age at death of 55 years for the general population. Repeated studies have shown a prevalence similar to that of tuberculosis. In 1938 there were in New York City five times as many deaths from this one disease as from measles, diphtheria, scarlet fever, infantile paralysis and cerebrospinal meningitis combined.

During the war, the services reported a wide prevalence of this disease and since in the majority of cases the attacks were initial ones the ultimate cost to the government will undoubtedly be tremendous. Admittedly, we still know far too little about the etiology of this disease and wide research is sorely needed. Nevertheless, the author goes on, much can be done to lighten the burden on the individual and the community by the organization of community rheumatic fever programs which can provide the following types of service:

1. Central integrating agencies where all community facilities for the care and diagnosis of patients can be pooled. The local health department can readily be utilized for this purpose.

2. Complete medical service to include diagnosis, treatment and follow-up in the offices of private physicians, in clinics, hospitals and sanatoriums. Of prime importance in this connection is the provision of either a cardiologist or cardiac clinic that will cooperate in every possible way with the private physician.

3. Adequate nursing service in the

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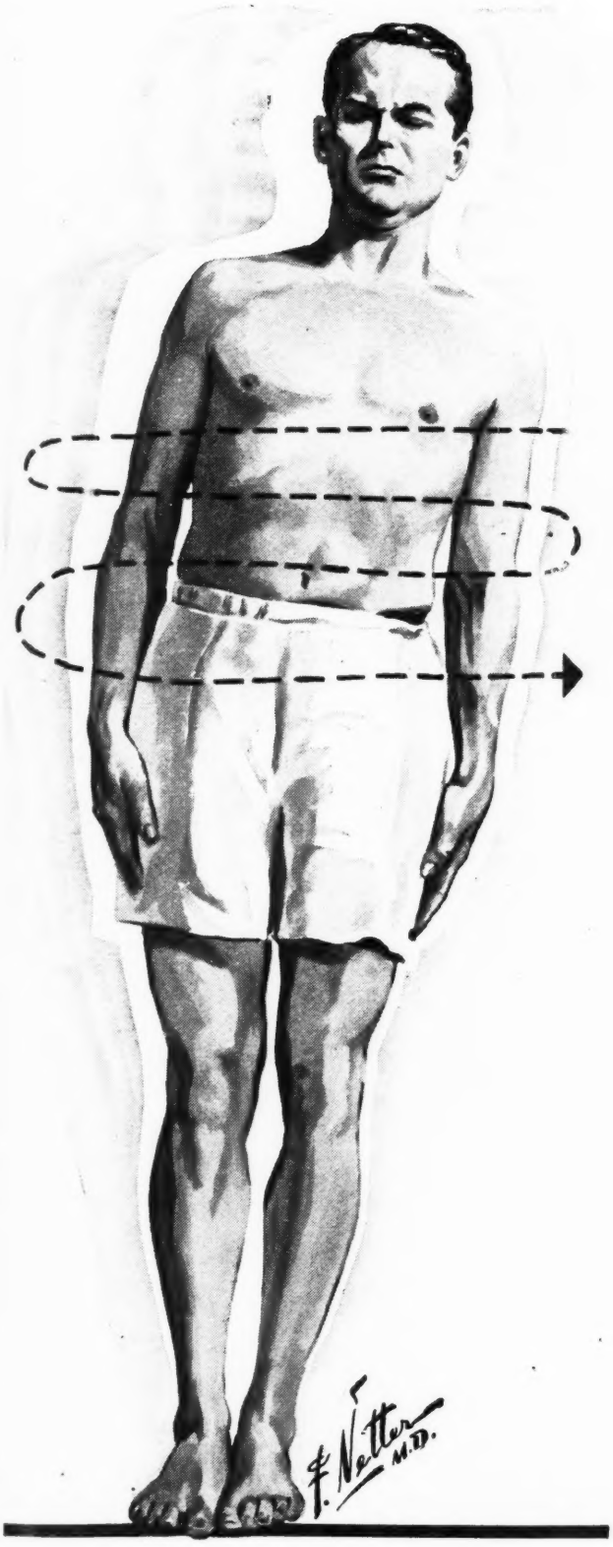
● As a relief measure in a sprain or backache, as a means of keeping a hot dressing hot, or as a source of comfort in sinusitis and chest conditions, the cleanliness, convenience and efficiency of a Burdick Zoalite indicate its use.

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For information on the Zoalites, drop us a line, The Burdick Corporation, Milton, Wisconsin, or contact your local Burdick dealer.

Burdick

THE BURDICK CORPORATION



POSITIVE ROMBERG

A positive Romberg test (Brauch-Romberg symptom) is one of the more characteristic evidences of cord involvement in pernicious anemia. Because of impaired position sense, the patient sways from side to side when he stands with feet together and eyes closed.

Early, adequate and persistent therapy is essential for the prevention or control of spinal cord affection in pernicious anemia. This is most important since neural involvement may cripple or incapacitate the patient. The *quality* of the liver preparation employed thus becomes of utmost significance. In the production of ARMOUR LIVER PREPARATIONS every precaution is taken to assure therapeutic efficacy. The ARMOUR LABORATORIES has available the world's largest supply of fresh raw animal material. Skill and care are exercised to preserve the active blood regenerating constituents of the fresh liver—the hemopoietic principle as well as secondary factors. The finished products are tested for potency on actual pernicious anemia patients in relapse.

Have confidence in the preparation
you prescribe—specify "ARMOUR"

ARMOUR

Liver Preparations

Liver Liquid Parenteral
4 U. S. P. Injectable Units per cc. (Crude). 1 cc., 5 cc., and 10 cc. rubber-capped vials. A preparation retaining the secondary hemopoietic factors and most of the vitamin content of the liver.

10 U. S. P. Injectable Units per cc. 1 cc., 5 cc. and 10 cc. rubber-capped vials.

15 U. S. P. Injectable Units per cc. 1 cc., 5 cc., and 10 cc. rubber-capped vials. A highly refined and concentrated preparation for massive dosage.

Solution Liver Extract—Oral
45 cc. equal 1 U. S. P. Oral Unit. A readily assimilable and therapeutically effective preparation for use when the oral route is indicated or preferred.

Liver Extract Concentrate—Capsules
9 capsules equal 1 U. S. P. Oral Unit. Odorless and tasteless. Sealed gelatin capsules in boxes of 50 and 100.

THE *Armour* LABORATORIES

HEADQUARTERS FOR MEDICINALS OF ANIMAL ORIGIN • CHICAGO 9, ILLINOIS

clinic, hospital, convalescent home and patient's home.

4. Professional education for physicians, nurses, medical social workers, school teachers and representatives of all agencies in the rheumatic fever program.

5. Lay education primarily to provide proper financial support for the program.

6. Provision for guidance and evaluation of the effectiveness of such programs which can best be obtained by coordination on a national level. Such coordination is today afforded by the American Council on Rheumatic Fever of the American Heart Association.

In conclusion, the author emphasizes that rheumatic fever and rheumatic heart disease are today a national public health problem of serious proportions. It is important that public health agencies meet this problem on the basis of established clinical and epidemiological facts in accordance with sound administrative principles. — ALEXANDER W. KRUGER, M.D.

Value of Cough Syrup

Are there any therapeutic effects of simple syrups in the treatment of cough and shall their use be continued? Eldon M. Boyd, M.D., in an interesting article, "The Cough Syrup," published in the Nov. 16, 1946, issue of the *British Medical Journal*, answers these questions.

In an experiment conducted with 28 patients suffering from cough resulting from a common cold, 68 per cent got complete relief from cough when simple syrup was administered and 32 per cent got little or no relief. Syrup had anticough properties which lasted for about two hours.

Further experiments in which syrup was given by stomach tube to animals did not augment the output of respiratory tract fluid and, in view of the short anticough action of the syrup in man, it may be concluded that syrup taken by mouth soothed the irritated pharynx and upper respiratory tract irritation which was responsible for cough in about two thirds of the patients studied. The evidence favors the retention of syrup as a vehicle for expectorant and anticough medicines.

Another investigation was conducted to show whether syrups alone have a true expectorant action. It was necessary to investigate those pharmacologic and therapeutic properties of reputed expectorants which might offer an explanation of their mode of action. Quantitative measurements of the output of bronchial secretions or respiratory tract fluids had to be taken. The technic for measurement was developed and it has been possible to measure the effect upon the output and composition of respiratory tract fluid of many drugs.

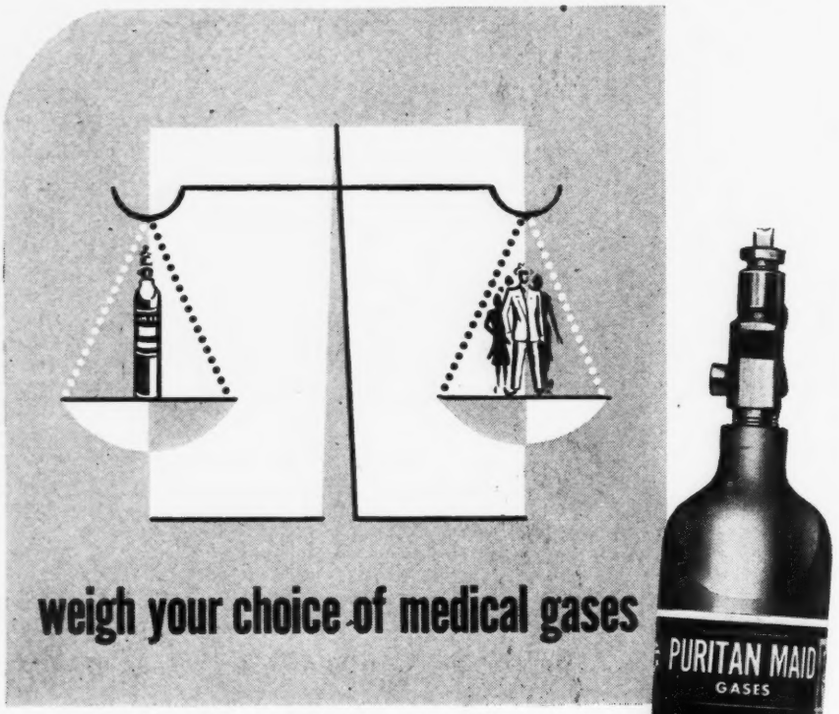
The same technic was applied to a study of the effect of several pharmacopoeial syrups on the rate of respiratory tract fluid in approximately 200 animals. The result showed that syrup in a cough syrup has little or no effect on the rate of output of respiratory tract fluid when given by stomach tube.

The results of experiments on animals and man indicated the following:

1. The syrupy vehicle of a cough syrup exerts a short soothing effect on the mucosa of the pharynx and upper respiratory tract, and if the cough is due to irritation of this mucosa the syrup has an anticough effect per se.

2. When the bulk of the syrup enters the stomach, it has little or no expectorant property since it does not increase the rate of output of soothing respiratory tract fluid.

3. Expectorant drugs added to the syrup exert an anticough action since they increase the output of respiratory tract fluid, at about the time the local anticough action of the syrup alone has begun to wear off. Thus, experiments prove that the use of expectorants in a vehicle of syrup, producing a cough syrup, is justified.—IRVING GOTTSEGEN.



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FOOD SERVICE

CONDUCTED BY MARY P. HUDDLESON

Food Sanitation

MURRAY P. HORWOOD

Professor of Sanitary Science, Massachusetts Institute of Technology

NO DINING SERVICE CAN BE REgarded as satisfactory unless it is clean, attractive and safe. Two of the primary essentials for safe and satisfactory dining service are a safe and abundant potable water supply and a safe milk and cream supply. It is important also that every dining service be connected directly to a public sewerage system or to a suitable private means of sewage disposal. Moreover, there should be an ample supply of hot water at all times. Water used for sterilizing dishes should be maintained at 170° F. or higher; for other purposes, at 145°-150° F.

HANDWASHING FACILITIES NEARBY

Suitable handwashing facilities should be provided in all toilets, kitchens and locker rooms. Such facilities should include a combination faucet for hot and cold running water, a sanitary soap dispenser filled with soap at all times, individual paper towels and a suitable receptacle for used towels. Employes should be instructed in the importance of good hand hygiene, particularly after using the toilet, after coughing or sneezing into the hand or a handkerchief, after every time hands are soiled and before starting work in the morning and after lunch. Too, satisfactory showers should be available for the employes.

A suitable system of collecting and storing all garbage and refuse is essential. Such wastes should be stored preferably in a separate room opening to the out of doors. The room should have a smooth and entire cement floor and the floor should have a drain connected to the sewer. Doors and windows should be thoroughly screened. The room itself should be ratproof. All refuse should be stored in clean barrels or other suitable receptacles; the garbage, in clean, metal barrels equipped with tight-fitting metal covers.

All receptacles should be placed 1 foot away from the wall on a metal pipe platform or a platform made of concrete strips. The platform should be at least 12 inches above the floor to facilitate cleaning and to prevent the creation of rat harborages. Running hot and cold water and a hose and nozzle should be available for washing garbage and rubbish barrels and for keeping the floor clean.

In regard to infections and poisonings associated with foods, if the foods are clean and wholesome when purchased; if they are bought from a reliable dealer; if meats are stamped "U. S. Inspected"; if the foods are handled by clean, healthy workers who are not carriers of disease, and if the foods are thoroughly cooked and served promptly or, if not served immediately, are refrigerated properly until they are ready to be served, then the danger of foodborne infections will be practically eliminated.

A hazard is introduced as soon as one of these provisos is lacking. Commercially canned foods are invariably safe and the record achieved in this respect in this country is remarkable.

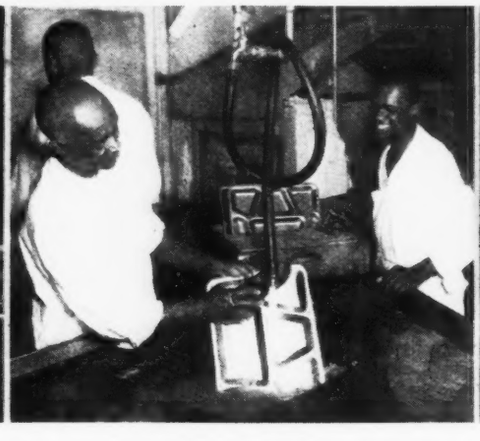
All food handlers should be free of disease and should not be carriers of disease. Individuals who have had typhoid fever preferably should not be employed as food handlers. This becomes mandatory if examination discloses that the individual is a carrier.

CHEST X-RAYS ANNUALLY

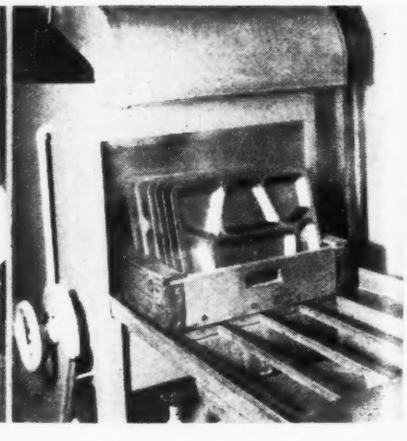
While public health officials do not favor the certification of food handlers following an annual medical examination mainly because the individual may become infected shortly afterward, it is becoming general practice to require all food handlers to have an annual x-ray examination of the chest for tuberculosis. Food handlers who are ill with respiratory disease of any kind



Scraping dishes



Pre-rinsing the dishes



Tray washer

should be encouraged to remain away from work until they are cured. Similarly, food handlers who have suppurating wounds on the hands, neck or any other part of the body should not be permitted to work until the wound has been thoroughly healed. Such individuals may be responsible for cases of Staphylococcus and Streptococcus food poisoning.

One of the most important requirements of good food sanitation is adequate and effective refrigeration. While health department regulations normally require refrigerating facilities to function at 50° F., it is preferable if the temperature of refrigeration is maintained at or near 40° F. The refrigerator should be clean at all times and the air should be in constant circulation. Foods should be separated to permit the cold air to circulate freely. They should not be packed too tightly for the same reason.

Subfreezing units should be available for meats, ice cream and other frozen foods. All eggs, bakery products, dairy products, custards, cream fillings, meats, meat products, fish, fish products, fresh vegetables, fruits, soups, sauces, gravy and even canned goods should be refrigerated when not in use.

It is a serious mistake to permit any raw or cooked foods to incubate in the warm atmosphere of the kitchen or service room when they are not being used. At such times, decomposition sets in and any infection that may be present is soon multiplied to a hazardous degree. The importance of refrigerating foods satisfactorily at all times when they are not in use cannot be overemphasized. Most food establishments frequently fail in this practice.

QUICK COOLING OF HOT FOODS

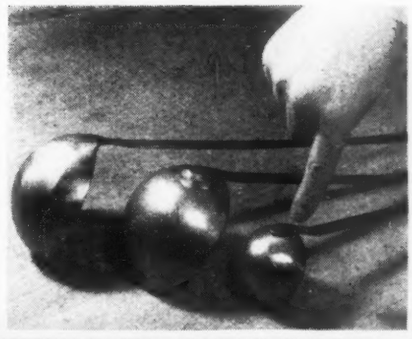
A serious fallacy widely held by many cooks is that prompt refrigeration of hot foods will produce souring. This view was undoubtedly correct in the days of iceboxes, especially in chests that were only partially filled with ice. The introduction of hot foods in such iceboxes caused the ice to melt and raised the temperature to a point favorable to bacterial multiplication and food spoilage.

With mechanical refrigeration, however, the conditions are different. While it may be uneconomical to introduce very hot foods into a mechanical refrigerator, it is undesirable to allow heated or cooked foods to remain in the warm atmosphere of the kitchen overnight or until they are stone cold. This is true of roasts, gravy, sauces, soups, custards and other foods. Such practices are dangerous and lead to food poisoning.

As soon as the excess heat of cooked foods has been dissipated, the foods should be placed in a mechanical refrigerator at 40° F. if they are not to be used immediately. Furthermore, every refrigerator should be equipped with a thermometer at all times and the temperature should be observed by a responsible person several times each day.

Milk should be served only in bottles and should be properly refrigerated at all times. It is a highly perishable food unless it is kept cold constantly. If the milk is not kept in a mechanical refrigerator at 40° F. it should be stored in a shallow pan containing ice water at all times. The level of the ice water should be almost up to the pouring lip of the bottle. The temperature of such milk will vary between 33° and 40° F. If the ice water is not up to the pouring lip, the bottom portion will be cold while the upper part which stands above the water may be warm. From time to time, it will be necessary to draw off some of the water to make room for additional cracked ice.

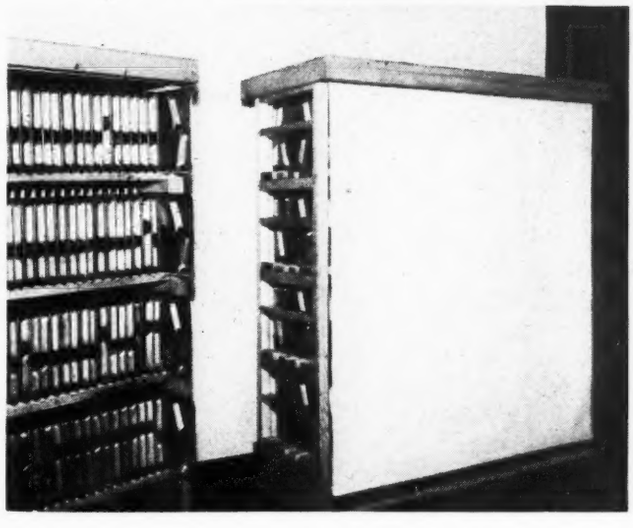
Cream ready for serving should be stored in a covered dispenser which is thoroughly refrigerated and insulated. The dispenser must have a smooth interior, be free of cracks, crevices and corners and be clean and sterile before it is filled. The dispenser should be emptied each day at the close of business, taken apart and thoroughly cleaned and sterilized. Every part of the dispenser that comes in





ABOVE: Ladle in one piece is more sanitary than two piece ladle. Crevices in the latter should be filled with stainless steel to prevent the accumulation of organic debris.

RIGHT: Arrangement of clean silverware at Graduate House dining service, M.I.T., is neat and safe.



LEFT: Nesting of trays should be avoided. Metal tray racks that allow for drainage are used in Graduate House dining room. Nor should dishes be nested unless thoroughly clean inside and out and entirely dry.

contact with the cream must be treated in this manner.

If necessary a strong chlorine solution should be employed to facilitate sterilization. After this has been done, the empty cream dispenser should be allowed to dry overnight. Precautions should be taken, however, to prevent contamination from the atmosphere as well as from vermin and rodents.

Foods must also be protected constantly against the depredations and contaminations resulting from rodents, vermin and flies. Flies may be a nuisance only during the fly breeding season but the other pests may be present in a food establishment throughout the year. While many establishments employ professional pest exterminators, such measures are only palliative and not corrective. In order to combat these pests effectively, it is necessary to combine constantly perfect sanitation with effective control measures.

Rodents and vermin will not become a problem if they do not have access to food and if all harborages are eliminated. However, these conditions can be attained only after constant and meticulous sanitary precautions.

The floors, table tops, workbenches and all equipment must be kept immaculately clean. All cracks and crevices must be eliminated wherever they occur. Cabinets, table tops, workbenches, equipment and almost everything used in the preparation, serving and storage of food must be made of smooth, nontoxic metal instead of wood. Even the steel runs of the doors of metal cabinets must be kept free of all food accumulations. All drawers should likewise be kept spotlessly clean. The various cutting and chopping implements and machines must be kept similarly free of all particles of food.

At the end of each day, all unused food should be stored in mechanical refrigerators and nonperishable foods should be placed in covered containers that are ratproof and verminproof. Only after such precautions can a food establishment be reasonably free of pests.

Storerooms should be organized so that everything will be kept at least 1 foot off the floor. For this purpose metal shelves or platforms should be provided. Beans, grains and dried foods should be stored in metal containers provided with tight fitting covers. Bags of flour and sugar should be stored on pipe platforms 1 foot from the wall and in small piles so as to prevent the formation of rat harborages and easy feeding platforms. The distance between piles should be 2 feet. All approaches from the floor and walls should be protected with spikes or with stout, smooth sheet metal. By exercising a little intelligence and constant care, rodents and vermin can be denied ready access to a bountiful food supply.

All openings to the out of doors should be made ratproof. Similarly, all holes in the floors or walls should be filled in or covered effectively with ratproof material. Pipes and ducts passing through walls and ceilings must be protected with tight fitting metal guards or the holes surrounding them must be filled in and made ratproof and verminproof. By ratproofing, by eliminating all harborages for rodents and vermin, by protecting all foods effectively and by practicing perfect sanitation the battle against all pests can be successful to an astonishing degree.

However, in addition to these measures it may be necessary to use poisons in order to achieve complete safety. All doors and windows should be thoroughly screened with 18 mesh screening during the fly breeding season. In addition, the screens should be painted or sprayed with a 10 per cent solution of DDT every six weeks from May 1 to October 1. The walls and pipes in the kitchen, workrooms and other parts of the dining service should be treated in a similar manner if a fly nuisance exists. If this is done, the DDT should be applied after all food has been removed and stored and after all equipment has been thoroughly protected.

Similarly, in combating vermin, a 10 per cent solution of DDT should be sprayed into cracks and crevices if any exist. Sometimes colored sodium fluoride is used for this purpose. When so employed, care must be taken to avoid contaminating the food and eating utensils as well as other equipment. Combating rodents with traps and poisons is a professional job and should be left to a professional exterminator. The successful use of poisons requires prebaiting and the subsequent use of toxic doses of effective poisons which will be sufficient for the purpose of killing rats. There should also be adequate follow-up work to remove and destroy all dead and trapped rodents. The ordinary operator of a dining service is not qualified to do this job effectively.



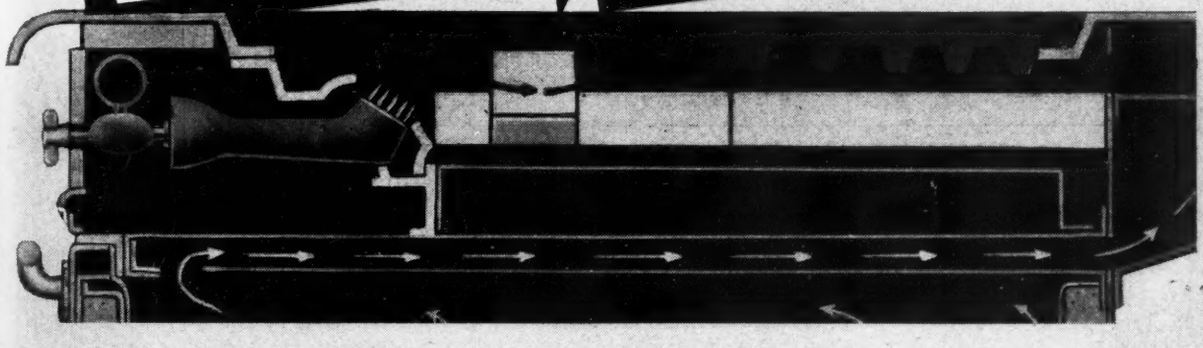
Desserts being stored for transfer to service counter at Walker-Memorial Dining Service, M.I.T. All racks are clean and covered with clean paper.

The sanitary care of equipment in a food establishment is also of great importance. The nesting of trays should be avoided. To achieve this goal, metal tray racks that allow for drainage should be provided. Similarly, dishes should not be nested unless they are thoroughly clean, inside and out, and are thoroughly dry.

Metal pie racks should be kept clean and the angle irons on which they rest should be free of all accumulations of food. The racks themselves should

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FRONT FIRING



Cross section of Garland All-Hot Top—Front to back view.

for *unlimited* control of heat on the HOT TOP

Notice the location of the burner in the cross section of the Garland All-Hot Top above. With the burner "on," the front of the All-Hot Top will become hottest with temperature gradually receding toward the rear. For high heat, the chef keeps pots, pans and skillets at the front, moving them to the rear as lower heats are needed. Because all seven Garland burners are front fired and individually controlled, the chef can secure an infinite number of heat variations in various sections of the All-Hot Top as needed. This means he can cook more food—better and more economically. *No other commercial range has the front firing feature.* Available for manufactured, natural or L-P gas.



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GARLAND All-Hot Top Range No. 45-28CX

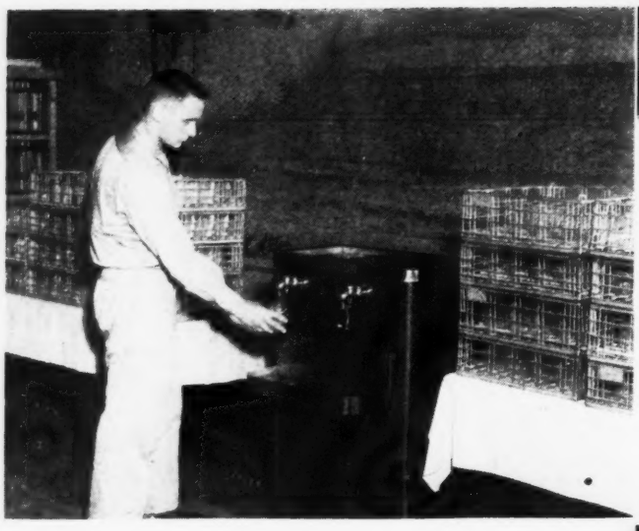
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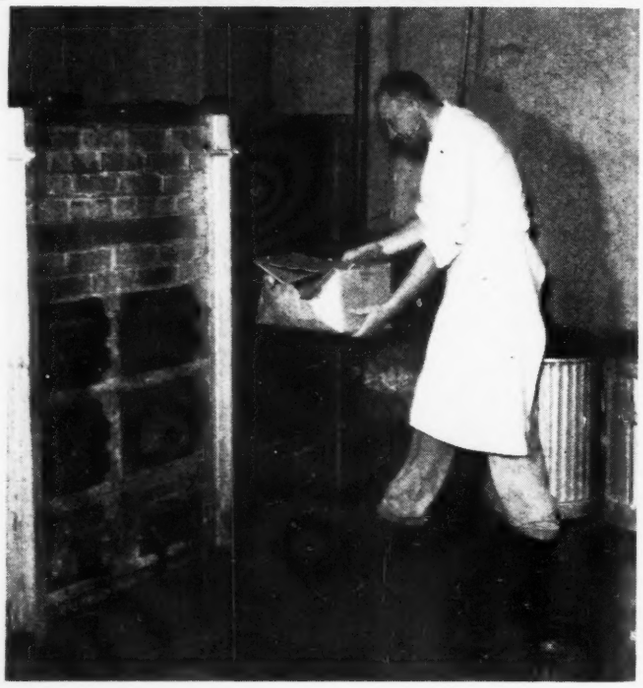
be covered with clean paper constantly to facilitate cleanliness. Bread cabinets should be clean and well ventilated and should be free of crumbs. The shelves should likewise be lined with clean paper. Cake cabinets should be treated similarly.

Brooms and mops should be stored off the floor.

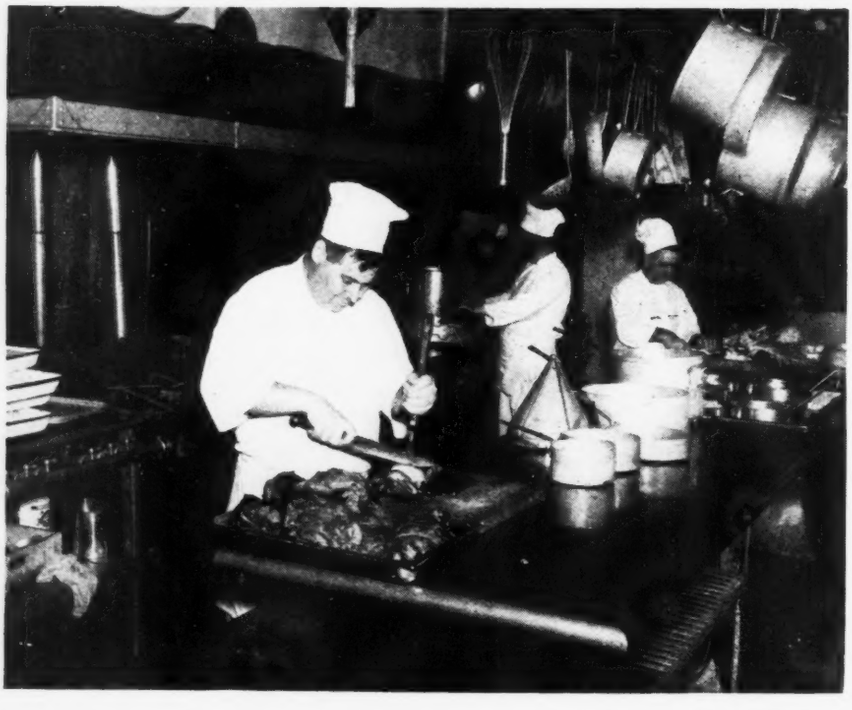
Finally, deep fat fryers should be protected against spillage by means of suitable metal guards and the floor and hood should be kept free of all accumulations of grease.

It must be evident that the problem of food sanitation is complex and difficult. The solution of this problem requires knowledge of the principles underlying food contamination, food spoilage and food-borne infections. It requires constant care and strict adherence to sanitary procedures. It requires daily intelligent supervision by a responsible person.

TOP: Glass sanitation and refrigerated cream dispenser. RIGHT: Incinerator in use for combustible rubbish at Walker-Memorial Dining Hall.



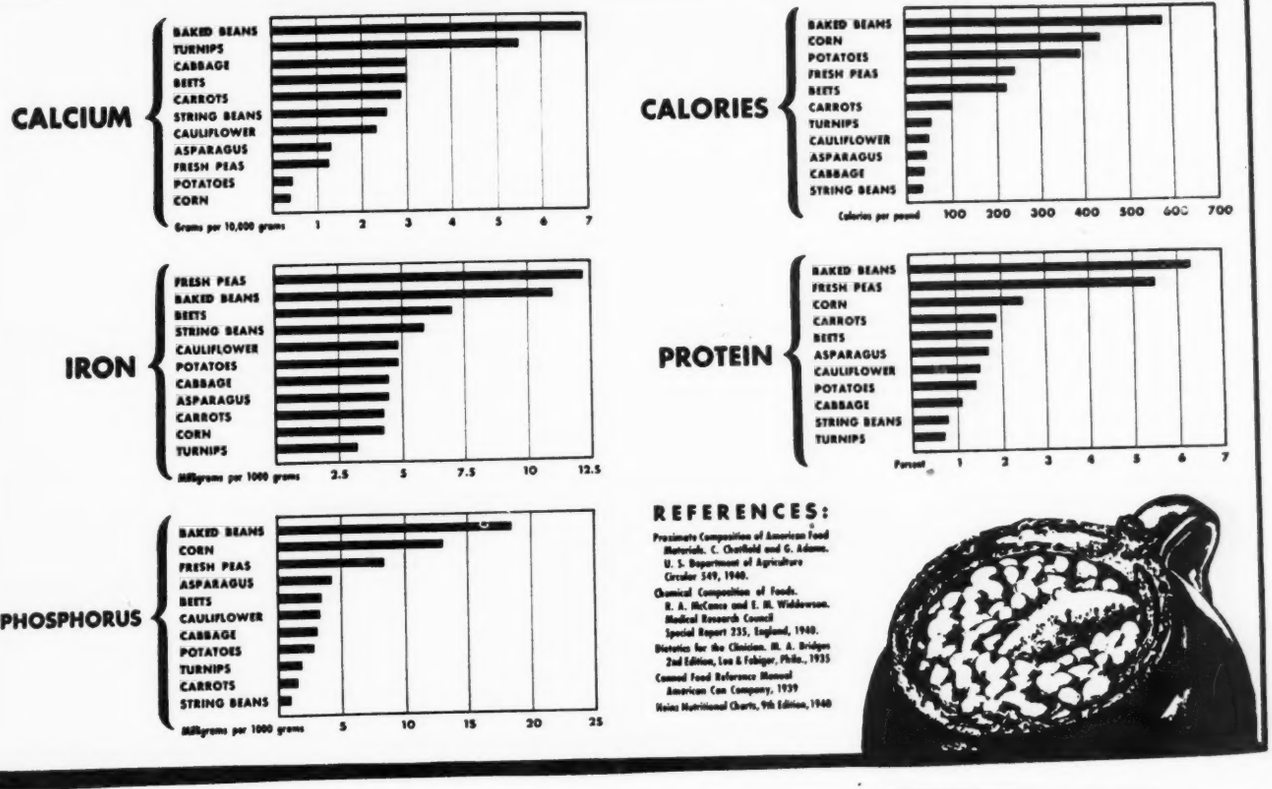
BELOW: View of the sanitary kitchen, also at Walker-Memorial at M.I.T.



While educational measures such as classes, lectures, moving pictures, stereopticon slides and posters are helpful in developing trained personnel, nothing can take the place of careful, detailed instruction by demonstration while the man is on the job. Furthermore, no teacher can be more effective than the boss who takes the time and makes the effort to show the worker how the job should be done. When the operating personnel has been trained in this way to function as an intelligent, efficient team, highly satisfactory conditions will prevail. Then food sanitation will have been achieved, food infections will be under control, and the establishment will be highly regarded throughout the hospital community.

Heinz Oven-Baked Beans
. . . A GREAT FOOD VALUE!

On Every Count Baked Beans Stand High Among Cooked Vegetables



REFERENCES:

Proximate Composition of American Food Materials. C. Chatfield and G. Adams. U. S. Department of Agriculture Circular 549, 1940.

Chemical Composition of Foods. R. A. McCance and E. M. Widdowson. Medical Research Council Special Report 235, England, 1940.

Dietetics for the Clinician. M. A. Bridges 2nd Edition, Lea & Febiger, Phila., 1935

Canned Food Reference Manual American Can Company, 1939

Heinz Nutritional Charts, 9th Edition, 1940

DELICIOUS Heinz Oven-Baked Beans come fully prepared—ready to heat and serve!

They are a hearty, appetizing meal by themselves—equally good when served with frankfurters, hamburgers, meatloaf or sandwich dishes. Heinz Oven-Baked Beans are richly nutritious—a great, stick-to-the-ribs energy-giving food, with the famous "home-tastin'" flavor that appeals to all appetites!

HEINZ OVEN-BAKED BEANS ARE MONEY SAVERS, TOO!

Institutional size—each tin will serve eighteen 6-oz. portions of hearty, appetizing, home-tastin' Heinz Baked Beans.

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Ask Your Heinz Man About

HEINZ OVEN-BAKED BEANS

Menus for August 1947

Iona Crawford
Flint-Goodridge Hospital
New Orleans

1
Spiced Baked Apples
Poached Eggs on Toast
•
Broiled Catfish
Stewed Corn
Coleslaw
Bran Muffins
Chilled Lemon Pudding
•
Savory Fish Casserole
Tossed Green Salad
Buttered Toast
Fruit Cup

2
Sliced Peaches
Codfish Cakes
•
Baked Macaroni and Cheese
Buttered Spinach
Harvard Beets
Black-Eyed Susan Salad
Sliced Melon
•
Bacon With Corn Fritters
Relish Plate
Brown Betty, Lemon Sauce

3
Tomato Juice
Eggs
Twin Mountain Muffins
•
Southern Fried Chicken
Steamed Rice With Gravy
Buttered String Beans
Pineapple Salad
Ice Cream
•
Sliced Ham
Tomato and Cucumber Salad
Peach Shortcake
Milk

4
Bananas
Bacon With Biscuits
•
Braised Liver
Spanish Rice
Fried Okra
Cucumber and Pepper Salad
Dutch Apple Cake
•
Lunch Meat Sandwich
Creamy Potato Salad
Celery Hearts
Fresh Fruit
Iced Cocoa

5
Watermelon
Scrambled Eggs
•
Beef and Noodle Casserole
Baked Stuffed Tomatoes
String Beans
Carrot and Raisin Salad
Molded Fruit
•
Cheese Toast
Buttered Peas
Sliced Cucumbers
Baked Apple

6
Blackberries With Cream
Cheese Omelet
•
Fricasseed Chicken
Rice With Gravy
Green Lima Beans
Asparagus Salad
Sliced Peaches With Whipped Cream
•
Tomato Juice
Ham Loaf
Glazed Carrots
Ice Cream and Cookies

7
Orange Juice
Baked Corned Beef Hash
•
Roast Beef
Escalloped Sweet Potatoes With Apple
Buttered Cauliflower
Tomato Salad
Sliced Cantaloupe
•
Stuffed Peppers
Baked Potatoes
Coleslaw
Fresh Fruit

8
Sliced Bananas
Scrambled Eggs
•
Fried Fish
Parsley Potatoes
Green Peas
Apple and Celery Salad
Cottage Pudding, Orange Sauce
•
Salmon Salad
Cheese Sticks
Sliced Cucumbers
Angel Fruit Pudding

9
Baked Apple
Welsh Rarebit on Toast
•
Veal Stew
Potatoes in Jackets
Lettuce With Cheese Dressing
Corn Bread
Butterscotch Bavarian With Whipped Topping
•
Baked Corned Beef Hash
Mexican Slaw
Cottage Pudding With Orange Sauce

10
Cantaloupe
Plain Omelet
•
Roast Chicken, Corn Bread Dressing
Cranberry Sauce
Sautéed Squash and Onions
Tomato and Pepper Salad
Sliced Watermelon
•
Jellied Tuna Loaf, Russian Dressing
Asparagus Salad
Fresh Fruit Cup
Milk

11
Steamed Raisins
French Toast, Jam
•
Hot Roast Sandwich
Grilled Tomatoes
Raw Vegetable Salad
Apricot Bavarian
•
Broiled Bologna
Creole Corn
Cantaloupe

12
Frosted Grapes
Cheese Fondue
•
Creole Hamburger
Steamed Rice
Perfection Salad
Spiced Cup Cakes
•
Ham Sandwich
Avocado and Cottage Cheese Salad
Cookies
Lemonade

13
Fresh Pears
Bacon and Poached Egg
•
Sliced Baked Chicken
Mashed Potatoes
Green Beans
Shamrock Salad
Sliced Watermelon
•
Baked Rice and Cheese
Coleslaw
Fruit Gelatin With Custard Sauce

14
Orange
Salmon Croquettes
•
Broiled Liver
Creole Eggplant
Green Peas
Relish Plate
Cantaloupe à la Mode
•
Deviled Eggs
Peanut Butter Sandwich
Asparagus Salad
Banana

15
Melon
Plain Omelet
•
Broiled Trout
Candied Yams
Mexican Slaw
Lemon Pudding
•
Salmon Loaf
Creamed Peas and Carrots
Molded Spiced Fruit Salad

16
Stewed Figs
Beef Hash
•
Corn Pudding
Fried Okra
Mustard Greens
Corn Muffins
Dutch Apple Cake
•
Lunch Meat Sandwich
Tomato Salad
Cookies
Fruit Punch

17
Frosted Grapes
Ham and Eggs
•
Veal Cutlets
Mashed Potatoes
Broccoli With Hollandaise Sauce
Relish Plate
Peach Upside-Down Cake With Whipped Cream
•
Apple and Celery Salad
Peanut Butter Sandwich
Raspberry Gelatin

18
Muskmelon
Bacon, Cheese Toast
•
Spanish Meat Balls
Steamed Rice
Green Lima Beans
Shredded Lettuce, French Dressing
Fresh Fruit Cup
•
Ham-Potato Croquettes
Avocado and Cottage Cheese Salad
Orange Cup Cakes

19
Banana
Baked Hash
•
Broiled Liver
Stewed Corn
Pickled Beets
Perfection Salad
Peach Cobbler
•
Deviled Eggs
Potato Salad
Sliced Tomatoes
Gelatin
Orangeade

20
Honeydew Melon
Soft Boiled Eggs
•
Creole Shrimp
Steamed Rice
Carrot and Raisin Salad
Banana Pudding
•
Salisbury Steak
Mexican Slaw
Cottage Pudding With Lemon Sauce

21
Grapefruit
Bacon and Toast
•
Chicken Pot Pie
Corn on the Cob
Baked Eggplant
Cucumber and Pepper Salad
Pineapple Ice
•
Creole Spaghetti
Mixed Vegetable Salad
Sliced Peaches

22
Stewed Figs
Welsh Rarebit on Toast
•
Broiled Spanish Mackerel
Mashed Potatoes
Cabbage and Carrot Salad
Spoon Bread
Lemon Gelatin
•
Stuffed Peppers
Sliced Tomatoes
Carrot Sticks
Dainty Rice Pudding

23
Orange
Poached Egg on Toast
•
Broiled Liver
Buttered Noodles
Sautéed Tomatoes and Okra
Fresh Fruit Cup
•
Steamed Frankfurters on Toasted Buns
Coleslaw
Sliced Watermelon

24
Grapefruit
Bacon, Scrambled Eggs
•
Fried Chicken
Candied Yams
Fresh Lima Beans
Tomato Aspic
Apple Pie à la Mode
•
Ham Sandwich
Lettuce Salad
Peach Shortcake
Milk

25
Cantaloupe
Bacon and Eggs
•
Broiled Liver
Mashed Potatoes
Spanish Green Beans
Relish Plate
(onion, radish, cucumber)
Banana Pudding
•
Creamed Ham and Celery on Toast
Sliced Tomatoes
Carrot Sticks
Gelatin

26
Cooked Pears
Eggs à la Goldenrod
•
Baked Ham
Glazed Sweet Potatoes
Boiled Kale
Grapefruit and Orange Salad
Apple Snow
•
Creole Spaghetti
Shamrock Salad
Ice Box Cake

27
Baked Apple
Cheese Fondue
•
Baked Chicken and Noodles en Casserole
Green Peas
Stuffed Celery
Sliced Melon
•
Meat Roll
Sliced Tomatoes
French Fried Eggplant
Gelatin

28
Grapes
Bacon and Eggs
•
Swiss Steak
Parsley Potatoes
French Fried Eggplant
Cabbage and Carrot Salad
Lemon Sherbet
•
Baked Rice and Cheese
Sautéed Tomatoes and Okra
Jelly Roll

29
Fresh Peaches
Cheese Toast
•
Codfish Balls, Pea Sauce
Buttered Spinach
Avocada and Grapefruit Salad
Spanish Cream
•
Casserole of Rice and Tuna
Tomato and Cheese Salad
Cookies
Lemonade

30
Bananas
Bacon, Hot Biscuits
•
Vegetable Pie
Baked Potatoes
Buttered Beets
Sliced Orange Salad
Brown Betty
•
Braised Tongue
Creole Eggplant
Fresh Fruit Cup

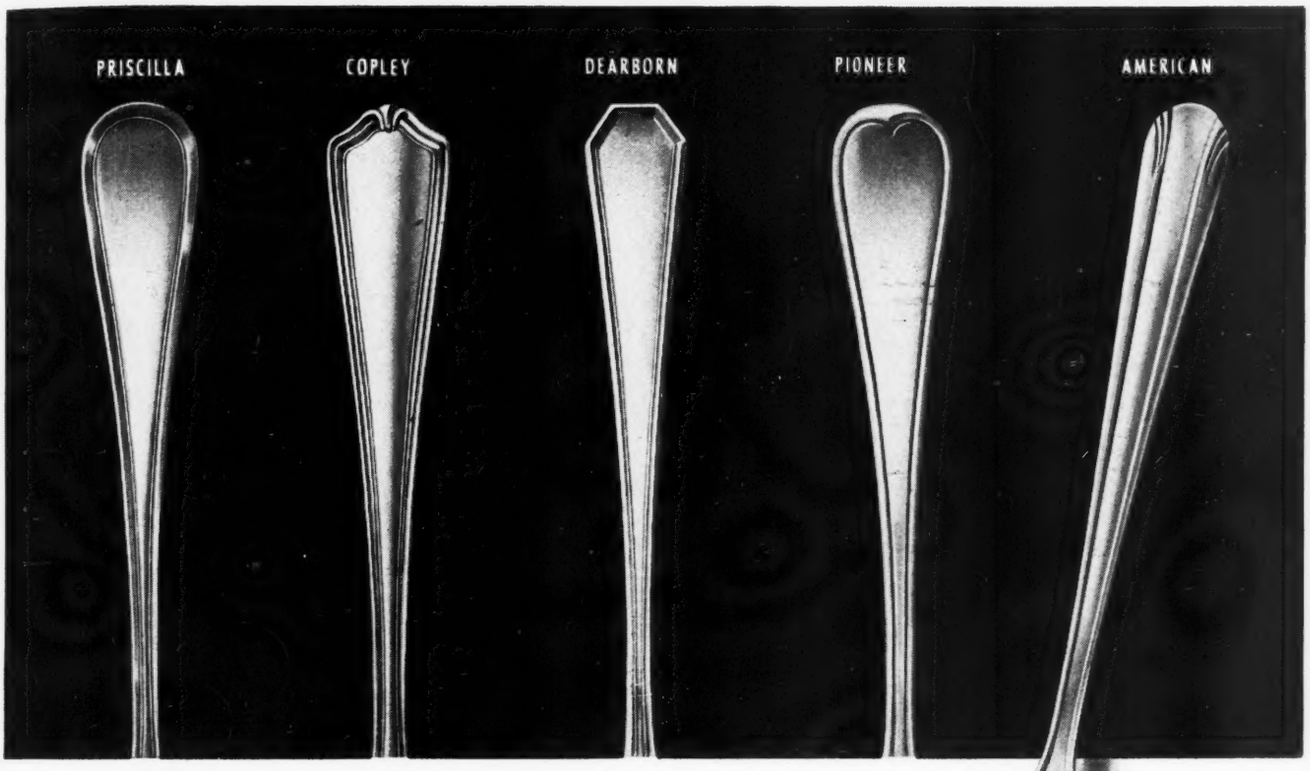
31 Honeydew Melon, Spanish Omelet • Roast Lamb, Mint Sauce, Mashed Potatoes, Buttered Green Peas, Carrot and Celery Salad, Ice Cream, Cookies • Creole Shrimp With Rice, Buttered Asparagus, Bananas

Ready-to-eat or cooked cereals are offered on all breakfast menus.

Note: Some of the fruits and vegetables may seem on the expensive side but are abundant and comparatively low in cost in this vicinity.

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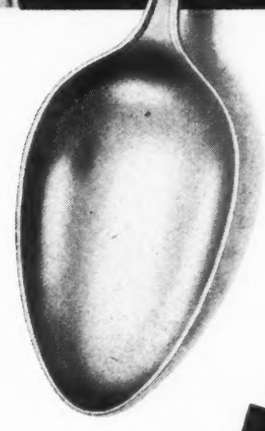
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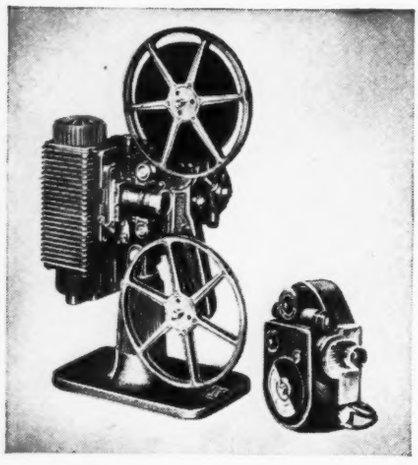
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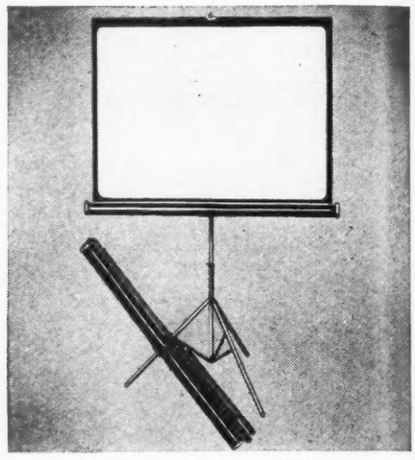
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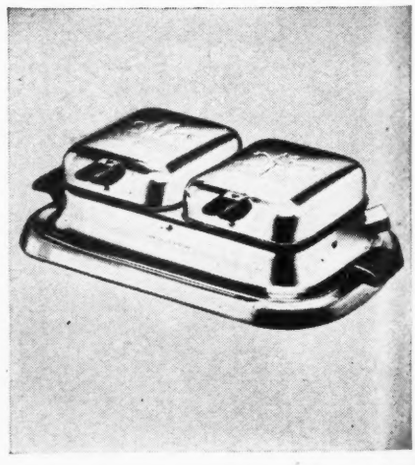


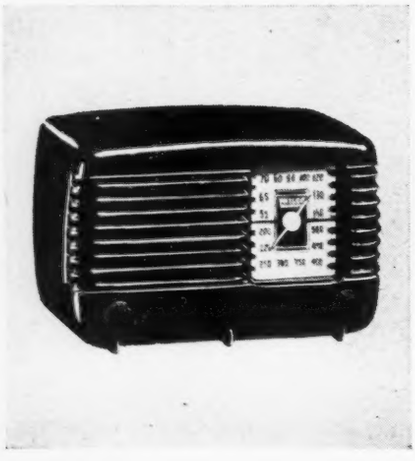






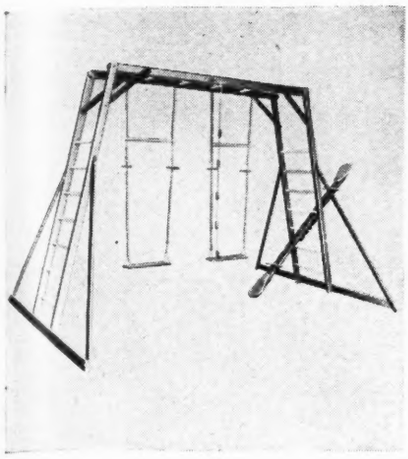




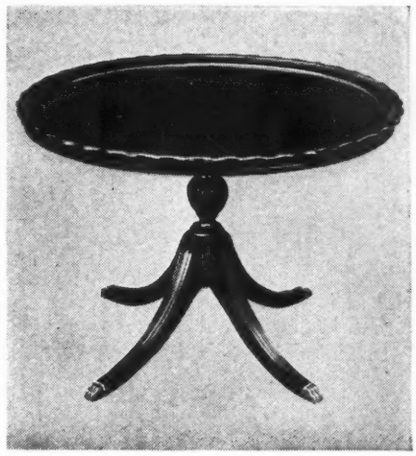












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Phosphorus	210.	milligrams
Iron	1.7	milligrams
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PLANT OPERATION & MAINTENANCE

Fireproof Is a Dangerous Word

DOROTHY PELLENZ
Superintendent
Crouse-Irving Hospital
Syracuse, N. Y.

No building is entirely safe without adequate protective devices and administrative controls

IT IS generally agreed that fire is the No. 1 enemy in hospitals, the greatest threat to life to the largest number of people. Second to loss of life, loss of use of even part of the building is extremely serious in these days of material shortages.

Recent tragic fires in so-called fireproof hotels have caused a wave of fire consciousness. This is evidenced by present activity of various fire fighting organizations, including a national conference in Washington, called by President Truman, to modernize building practices, encourage installation of protective devices, strengthen law enforcement and generally arouse the public to a more effective understanding of fire prevention principles.

Hotels Take the Lead

Without waiting for public action, the American Hotel Association has hired expert advisers and has pledged funds to carry out recommended procedures for better safety. The leadership of the hotels is a challenge to hospitals.

Hospitals have a double responsibility. Most of our patients are not able to take advantage of the safety measures that are open to an able bodied hotel guest. Our employes are constrained by duty and tradition to remain with or save helpless charges. Are we fully meeting the trust imposed upon us by these patients and their relatives and friends? Before we reject the thought that "we" are not in the same position as the hotels, let us take stock.

How safe are our hospitals? Voluminous statistics prove an alarming number of hospital fires, resulting in loss of life, injury and enormous property damage. Forty-seven per cent of institutional fires occur in general hospitals, and 52 per cent of these happen at night, emphasizing the importance of mechanical safeguards that do not depend upon the presence of all personnel.

Roughly, there are two classes of hospitals: those admittedly of old construction, which probably do not conform to modern fireproof standards, and those reasonably modern ones that are considered fireproof and entirely safe.

The administrator of the old hospital is likely to be highly fire conscious but hopeless that any real improvement can be made; or he may have done the best job possible in prevention and fire fighting organization. The head of the modern building may be lulled into a sense of dangerous false security behind the term "fireproof."

The definition of "fireproof" by the National Board of Fire Underwriters is: "A type of construction in which the contents of a building can be completely destroyed and yet the framework of the building, including the interior, will be capable of being rehabilitated and continued in use.

"The term 'fireproof' as applied to a hotel or other institution should not be used, even though the structure of the building is fireproof construction, unless all vertical openings, such as stairs, elevators and other shafts, are enclosed with partitions and have fire doors on all openings (thus preventing the upward travel of fire from one floor to another). Also, the separation partitions and doorways between rooms and corridor must be of such type as to prevent the ready spread of fire from room to corridor or from corridor to room. This last means that there shall be no transom, and that any air conditioning system shall be of such design as not to permit the travel of heated poisonous gases into rooms."

Thus, even fire resistant buildings are not necessarily fireproof, unless accompanied by other important safety factors.

Which Group Are We In?

There are, of course, hospitals that meet these rigid fireproof requirements, but for safety's sake let us be sure to which group we actually belong.

What constitutes adequate standards for fire safety? This question probably concerns the majority of administrators. There is no royal road to safety, but to a degree safety can be bought.

The National Fire Protective Association divides safety into two groups: (1) proper building and equipment protection; (2) adequate administrative controls.

Building safety includes the following:

1. A completely fireproof building, according to the rigid code previously described, or a fire resistive building plus protection of vertical

Condensed from a paper presented at the meeting of the New York State Hospital Association, 1947.

The Curtain is Going UP!

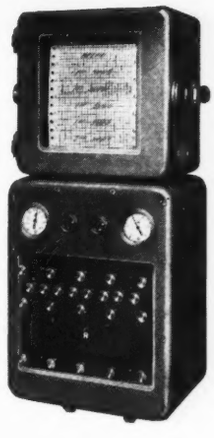
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Accurately and automatically controls and maintains any one of the several predetermined wash formulas you select. This exact, measured operation conserves linen and saves water, soap and other supplies since no more (and no less) are used than is required. More and better washes are possible with less washer time and floor space.

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openings to prevent the spread of smoke and fire and gases, which may be just as disastrous as actual fire.

2. Adequate exits, at least two from each area.

3. Segregation of hazards, *i.e.* boiler room, kitchen, laundry, paint shop, in a special building or in a specially protected area.

4. Proper installation of heating, ventilating and air conditioning equipment.

Under mechanical aids we find:

1. Automatic sprinklers throughout hospitals of combustible construction and in all hazardous areas of buildings of fire resistive construction.

2. Standpipes and hose where indicated (large buildings).

3. Good water supply, *i.e.* available hydrants, properly placed throughout the building.

4. Alarm systems to ensure prompt notification of the fire department. Also, automatic alarms to provide prompt detection of fire in storerooms, attics and other unoccupied areas.

Administrator Is Responsible

Under administrative controls are included:

1. Drills and training of personnel.

2. Observance of National Electrical Code (second cause of fires).

3. Control of smoking (most frequent cause of fires). It is recommended that smoking be restricted to safe areas rather than completely prohibited.

4. Proper safeguards in connection with the use and storage of explosive gases and anesthetics.

5. Good housekeeping, proper maintenance of equipment and storage.

All this seems like a tall order, but everything on this list can be bought, including the services of experts to train our personnel, if we are willing to pay the price.

Building changes in many cases may be prohibitive as to labor and cost. In these instances, we should not overlook the value of the automatic devices. They may pay for themselves in reduced fire rates. The value of automatic sprinklers as fire protection of the highest order appears first on the list in every piece of literature on the subject. These mechanical aids, I am told, are lacking in many unsafe institutions. Have they been overlooked? Mistakenly discarded as unnecessary? Or considered too expensive?

What is the responsibility of the administrator? Here is the view of a safety engineer who inspects hundreds of hospitals throughout the country:

"One of the greatest laxities is the absolute indifference of the average hospital administrator to the importance of a preconceived and well rehearsed plan of action, whether it is a fire drill or evacuation plan.

"Many hospital superintendents have stated that they lie awake nights worrying about fire, many with good cause, in old buildings; yet how few actually take concrete and substantial precautions, at least to evacuate the patients and personnel with a minimum loss of life even though the building factor has not even been considered.

"It would appear that futility bordering on hopelessness seems to prevail among administrators when they are confronted with an old structure instead of making elementary improvements with the installation of known devices, such as sprinkler systems, smoke detection devices and watchmen service, all worked into a program that includes monthly drills and the correct use of first aid appliances, such as fire extinguishers."

This drastic indictment seems to place a definite personal responsibility directly on the administrator. Certainly the administrator would be called upon to answer the fire marshal, coroner and investigators in case of a fatal fire.

While the administrator may not have authority to carry out needed reforms, he should know what they are, provide the leadership to obtain them or be on record as having advised his board and the community of the needs.

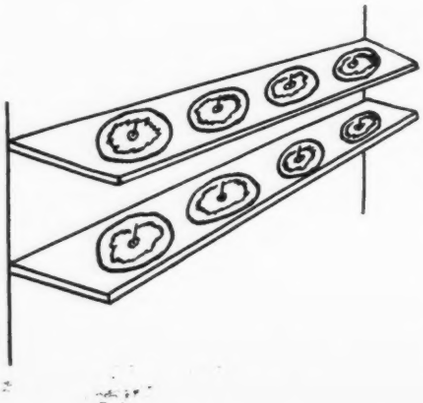
Administrators and boards should be progressive enough to seek this knowledge, not wait for outside agencies to force it upon them. In the light of new developments they will face the question of making retroactive for existing buildings changes or equipment that may run into considerable investment. Here they must decide on their moral responsibility to make older buildings equally as safe as those built under the stricter modern codes. Safe hospitals should be a community responsibility; it is unlikely that an appeal for funds to guarantee safety to the sick would not receive wholehearted support.

Even if you are sure your hospital is safe, why not get your opinion backed up by one who knows? If you are not sure, you cannot afford to forego this duty. Why not hire "safety" counsel the same as you would legal counsel, and have a "safety audit" as you would have a financial audit?

Let your board have the facts and share the responsibility.

Charts Are Where You Want Them

THIS sketch shows how a prominent plant solves its recording charts problem. Two shelves are arranged as indicated, slightly sloping and at convenient height for easy reading. There are eight recorders in the plant, hence eight pegs in the shelves. The latest charts are always kept on top. Each peg is clearly marked so that the charts from the same recorder are always placed on that peg. The shelves are amply wide and the pegs are spaced far enough apart so that there is plenty of clearance and no overlapping. Charts covering a full week are always kept on these pegs, previous ones being systematically filed away as a permanent record.—W. I. SCHAPHORST, M.E., *Newark, N. J.*





Photograph of Surgeons' Scrub-up Room, St. Francis Hospital, Evanston, Illinois—where Duraclay sinks have been in service for six years.

Duraclay *

on the job 6 years—still like new

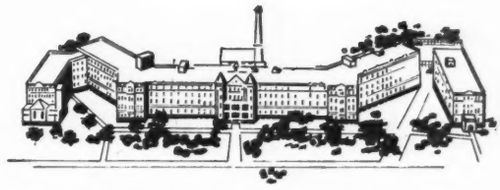
In hospital plumbing fixtures you want a material that will give years of service and still remain sparkling and white.

You want a material that will stand sudden changes in temperature without cracking or crazing.

You want a material that is not subject to staining, that is unaffected by acids—that will stand abrasion.

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* ***Duraclay*** exceeds the rigid tests imposed on earthenware (vitreous glazed) established in Simplified Practice Recommendation R106-41 of the National Bureau of Standards.



In our hospital we installed Duraclay sinks six years ago, and despite the unusual service these past years have brought, this equipment still looks like new.

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It May Not Be Linen But It *Can* Be Controlled

VICTOR KRAMER
Laundry Management Consultant, New York City

IN most hospitals, "linen control" means neither linen nor control. The linen is cotton and control starts when the irate housekeeper storms into the administrator's office, announcing that there isn't a clean sheet to put on a bed.

A linen control system that works is rare. When it does, costs are low and every linen user in the hospital is satisfied. Good linen control is predicated on a master plan whose many variables are coordinated. It includes specific procedures for the following: purchase, fabrication within the hospital, storage, issuance, distribution, new and circulating inventory, laundering schedules, washing formulas, stain removal, mending and condemnation. For each phase, a few form records are needed and the whole cycle should be under the centralized management of one responsible department head.

Linen control makes possible a hard boiled, thorough analysis of the costs, and in great detail. It is the countless little leaks which bring the flood of wasted budget dollars. The moment the danger points are known at which linen is extravagantly used, abused, pilfered or bottlenecked in transit, losses can be stopped.

Now for some definite suggestions to achieve a well knit linen control system:

1. **Purchase.** Buy, long before you need, adequate sizes and upon comparative specifications.

Place orders only twice a year for all anticipated needs, including yard goods. Stagger deliveries if cash limitations are a factor. Thus the benefits of volume price and standardization of size and type of article will be obtained. The purchasing agent should concentrate on examining competitive bids and preventing inefficient hand to mouth buying for spot emergencies. Beware of the lowest price as the sole guide to action.

Purchase on specifications: thread count per square inch in warp and fill, ounce weight to the yard, breaking strength in pounds, per cent of sizing, shrinkage factor, length of cotton staple, construction details (as in patients' gowns, O.R. coats). When the housewife buys advertised trade brands at retail, she is intrigued by the smooth, glossy finish of the goods. Maybe it was produced by synthetic resins soon to "come out in the wash." The hospital is spending thousands of dollars. Each $2 sheet bought will wind up as a rag—limp, sleazy and frayed. But when? The rate of degradation will depend to some degree on what has been bought.

An era has just ended. O.P.A. is a memory, blessed or otherwise. So are 40 cents a pound cotton and acute linen shortages. The purchasing agent may now abandon the "pretty please" wheedling to which he has become addicted. The day of cajoling an indifferent jobber to yield up a few dozen sheets ("seconds" at ceiling price) is fortunately over. Intelligent, discriminating cotton buying is the first step in our program.

2. **Fabrication Within the Hospital.** Many items can be cut, hemmed and sewed at the hospital by volunteer guilds. This valuable service deserves encouragement, adequate facilities, appreciation and, in an unobtrusive way, control. The auxiliary should not be permitted to get "off the beam." The end product should not remain a mystery to the administrator. In the coming year, how many diapers, T binders, dish towels or whatnot will be supplied? Including cost of yard goods and hired seamstresses, what will the unit cost really be and is the whole project boondoggle or blessing?

3. **Control of Circulating Linen.** *Determine number of pieces of each kind needed for one complete setup in every department that uses linen.*

For example, assume a 100 bed hospital 100 per cent occupied. To cover the institution once, we need 100 patients' gowns, 100 pillow cases, 200 sheets. First, a master tabulation of standard requirements for one usage is needed.

Determine a quota of pieces needed in circulation to keep one in current use. Establish a factor of efficiency to fit local conditions.

To illustrate, assume the factor is 4. To provide each patient with 1 face towel per twenty-four hour day, we need 4 in circulation: 1 with the patient, 1 in the laundry, 1 in the linen closet, 1 to cover stain removal, weekend use, extra need or other emergency. Thus, the par stock for our 100 bed hospital may be 400 face towels in circulation, based upon 100 per cent census.

Take a physical inventory, counting each piece of circulating linen wherever it is located.

Repeat this disagreeable and complicated job four times a year. It should be carried out with great care. In the average hospital, no one knows how many pieces of linen are in circulation. Everyone knows that the hospital is "short of linen."

Take the par stock and subtract

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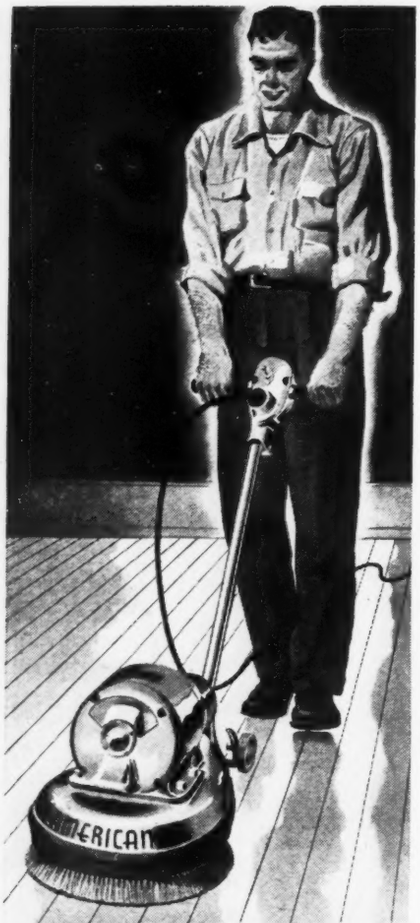
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the amount actually in circulation; the difference represents the number of pieces to be issued now to restore circulation to the approved quantities. Bring out the reserves and replenish linens to full strength. Repeat the process four times a year.

In short, effective linen control calls for a quarterly check. Take inventory of the new reserve and the circulating quantities; issue up to par stock, and discover how many pieces have been lost, stolen and destroyed. With this method, there should be no reason to issue new linens at any other time than at quarterly inventory periods. Frequent raids on the new linen reserves to meet recurring shortages spell lack of control and a high replacement cost. Now, having established a normal curve or rate of linen loss for your hospital, any increase from the norm is a clear warning signal for special investigation.

The very act of regular inventory taking offers psychological and deterrent values. The whole staff now understands that you are genuinely interested in the control and preservation of linen dollars. Even the habitual pilferers take a holiday. If a $100 petty cash fund is balanced to the penny, perhaps a $5000 circulating linen inventory deserves more than casual attention.

By regularized physical inventories of linens, new and in use, the percentage "write-off to linens" expense will tally with the facts of life. The books will record what is actually left on the shelves.

4. **How Much Is Enough?** What should our factor be? Enough to do the job. It is no economy to operate with a skimpy supply. Hot linen on the beds means higher production costs in the laundry, irritable nurses who cannot make up their beds on time and finally a breakdown of control. In war time many hospitals struggled through on a factor of 1¾ to 2¼ sets of linen and lived in a state of continuous crisis. For effective operation, a minimum of 3 is needed and better yet is a par of 4 complete sets.

5. **Distribution and Handling.**

Soiled Linen: Is it dropped by gravity chute or wheeled to laundry in trucks?

Clean Linen: Is it placed in the central linen room or taken directly to storage at point of use? If it is decentralized, are closets on each ward maintained to par by a requisition system or filled to a standard quota? Would an even exchange system fit your institution?

Usage: How many pounds of linen are allowed per patient day—9, 12, 15?

Marking: Are all hospital linens properly marked?

Linen Distributors: Under whose supervision do they work? What safeguards are used to keep them honest? Do they permit hoarding by some floors, causing a linen famine on others? Who plans their schedules to eliminate double handling? Are linen closets spot checked for condition?

Laundry Routine: Is the work processed on an individual lot basis? Is it presorted soiled or subsorted damp and later classified when ironed? Are the wash wheels fully loaded to rated capacity?

Jurisdiction: Are there areas of friction and occasional "border incidents" between housekeeper and laundry manager? Is the laundry manager in the subcellar on the organization chart also? Who is supposed to "control" linen?

Stained Pieces: Where are inspection and rejection of unusable pieces done? How are stained pieces reclaimed for general circulation?

Torn Pieces: What supervision is exercised over needless abuse of linen by employes and nurses? What percentage of pieces are torn daily? How are they segregated? Who supervises mending, "making little ones out of big ones"? How are cleaning rags prepared?

Condemnation: Who has authority to condemn a piece of linen for discard? What record is maintained of such condemnation?

Cost Control: Have all these functions been analyzed recently? Are you certain that the process is streamlined to be accomplished with the fewest man hours and the most effective flow of work to points at which it is needed?

To these and related questions, there can be no pat answer, no one best way. The variables are many: size of the hospital, structure of building, type of laundry equipment, relative tightness of linen in circulation and other items. Each situation requires a thorough survey and a plan engineered to fit the local circumstances.



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NEWS DIGEST

Fireworks Expected as Senate Resumes Hearings on Taft Health Proposal

By EVA ADAMS CROSS

WASHINGTON, D. C.—Hearings resumed June 25 on S. 545, Senator Taft's independent national health agency proposal, promised fireworks and a fine matching of wits, facts and figures in the controversial issue under consideration. So far only proponents of S. 545 have testified. But the present session will hear witnesses against S. 545. They are the supporters of S. 1320, the Murray, Wagner, Pepper, Chavez, Taylor, McGrath-National Health Insurance Bill.

The initial hearings which began in May brought out representatives from the American Hospital Association, the Catholic Hospital Association, the American Protestant Hospital Association, the American Medical Association, the American Dental Association, the Blue Cross and other groups. All of them backed the Taft bill in principle if not in detail.

John H. Hayes, president of A.H.A., flatly declared that compulsory health insurance at this time would lower the quality of American medical and hospital care. Testifying in favor of S. 545 Hayes spoke for more than 3800 association members representing 90 per cent of the civilian general hospital beds in the United States.

The federal government, in the A.H.A.'s opinion, could provide care to the needy veteran in his own community hospital at less expense than by the expenditure of countless millions of dollars for construction of a huge federal system of special hospitals where the difficulties of providing adequate and efficient hospital care are tremendous as well as expensive.

Mr. Hayes restated the 3 point resolution adopted by A.H.A. in 1944 with regard to the nation's health. This resolution embraced: extension of voluntary budgeting (prepayment) for the costs of medical and hospital care; government aid for public and voluntary construction of hospital facilities upon evidence of unmet needs, and local, county, state and federal government aid for the hospital and medical care of the indigent, with emphasis upon local participation.

The first recommendation, Mr. Hayes pointed out, is being met by Blue Cross plans for prepayment of hospital and medical care; the second, by the Hill-Burton Federal Hospital Survey and Construction Act, now in operation, and the third would be met by the Taft bill which stipulates local, county, state and federal aid for the hospital and medical care of the indigent.

A.M.A. President-Elect Sensenich contended that S. 545 provided plans for the interweaving of government and voluntary social and health agencies in such a manner as to permit the broadest variation in response to local needs. The American Medical Association is interested, he said, in the whole field of health and is desirous of bringing to every individual the benefits of the highest quality of medical care. Taft's bill provides the legislative basis for meeting the needs of the lower income groups without imposing a huge, expensive system of regimentation with its inevitable destruction of the quality of medical service, according to Dr. Sensenich.

Alphonse M. Schwitalla, S.J., former president of the Catholic Hospital Association, endorsed S. 545 for the following reasons: the bill takes care immediately of that fraction of the population which is most in need of health care, namely, the indigent, the semi-indigent, the medically indigent; in giving such care to these needy persons, the bill makes adequate provision for ensuring cooperation between the private and the public agency; it gives full consideration to local differences and individual rights.

Senate Bill 545, introduced in February by Senators Taft, Smith, Ball and Donnell, aims to coordinate the health functions of the federal government in a single agency to be headed by a physician outstanding in the field of medicine. It proposes federal grants-in-aid to the states for the establishment of medical and hospital services to persons whose low incomes make it impossible for them to have adequate care.

S. 1320, introduced May 20, would provide a national health insurance and public health program.

Department of Health, Education, Security Out of Committee

WASHINGTON, D. C.—The bill to create an executive department of the government to be known as the Department of Health, Education and Security came a little closer to enactment with its favorable reporting out of a Senate committee June 6.

The bill as reported by the committee establishes three bureaus: health, education and public welfare. Each bureau would be headed by an undersecretary, each of whom would be paid a salary of $12,000 yearly. Professional qualifications specified in the original bill have been omitted. High administrative qualifications were deemed by the committee as more needed than professional training. The existing office of Federal Security Administrator would have the status of a secretary.

The bureau of health would contain the U. S. Public Health Service, the Food and Drug Administration, Freedmen's Hospital and St. Elizabeths Hospital.

The bill provides for the appointment of advisory committees to advise and consult with the secretary with respect to major policies in the fields of health, education and public welfare. An amendment qualifies for appointment on such committees persons who are recognized as proficient in any health field under their respective state laws. The amendment was made to overcome the tendency under present administration of health programs to appoint only persons qualified in medicine to advisory committees.

The bill was amended to provide also that it does not give the new department any functions other than those authorized by previous legislation affecting the Federal Security Agency.

World Health Body Endorsed in Hearings

WASHINGTON, D. C.—Hearings were begun June 13 on H. J. Resolution 161, providing for membership and participation by the United States in the World Health Organization. Dr. Thomas Parran, surgeon general, U.S.P.H.S., and Representative Walter H. Judd testified at the initial hearing. The organization will promote exchange of information among nations on diseases as a part of its functions.

We can work with other nations to eliminate disease at its source or we can establish strict quarantine, Mr. Judd, a former medical missionary, said. Speed of modern travel has made successful quarantine impossible, he argued.

Dr. Parran cited the recent outbreak of smallpox in New York City, brought by a passenger on a bus from Mexico, as an example of the swift spread of disease under present day conditions.

Secretary Marshall, in endorsing the bill, declared that a world health organization will provide the international machinery to bring about conditions of health essential not only to the welfare of the United States but to a stable world order.



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Hinenburg Named New President of Hospital Association of New York State

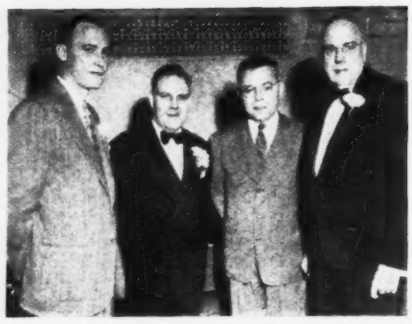
BUFFALO, N. Y.—Dr. Morris Hinenburg, administrator of the Jewish Hospital of Brooklyn, was named president of the Hospital Association of New York State at the association's annual meeting in Buffalo last month. Dr. Hinenburg succeeds Lee B. Mailler of Cornwall Hospital. Carl P. Wright for many years executive secretary of the New York Association resigned this position and urged an amendment to the association's constitution which would make possible employment of a full time secretary. Pending such an appointment, Mr. Wright agreed to carry on as secretary. In a convention address he urged administrators to make every possible effort to educate hospital trustees.

At a session devoted to discussion by hospital suppliers, Richard Ruslander of Buffalo, manufacturer of kitchen equipment, stated that most contractors and suppliers are now willing to make firm bids on the basis of their belief that prices have reached their peak. Delivery schedules are improving, Mr. Ruslander stated, and standard equipment items can be delivered within three to five months. Mr. Ruslander described several new kinds of labor saving devices for hospital food service departments. He urged administrators and dietitians to study labor saving layouts and equipment in order to reduce the cost of serving meals to patients and personnel.

Insurance Departments Critical

State insurance departments are becoming increasingly critical of larger payments to hospitals by Blue Cross plans, J. Campbell Butler, executive director, Group Hospital Service, Syracuse, told members of the association during a panel discussion on current hospital problems. Mr. Butler suggested that a joint committee representing the hospital association and Blue Cross plans in the state be organized to develop an accounting formula to stabilize the method of payment to hospitals in a pattern that would be satisfactory to hospitals, Blue Cross and the state insurance and social welfare departments. Mr. Butler also said there was a trend in some areas for employes of large national companies to leave Blue Cross for commercial insurance plans.

Speaking on current trends in personnel practice, Charles E. Fogg of the industrial relations department of the Du Pont Company warned against the tendency of management to "get tough with labor." Responsible labor leaders are taking a sober view of their relations with employers and the public, Mr. Fogg said. "We now have the best opportunity in history for management to cement really good relations with workers," he said. Mr. Fogg urged hospital administrators to establish clear cut, humane personnel policies and to create an atmosphere which will lead the worker to approach his job with a willing spirit.



Left to right: Lawrence Kresge; Moir P. Tanner; Dr. Morris Hinenburg; Lee Mailler.

"We must be firm and intelligent in our approach to the worker, pointing out why he must produce a full day's work in return for a good wage," Mr. Fogg said, but he added, "we are not going to do the job by getting tough."

In a discussion of nursing problems, Eva Erickson of Olean, N. Y., pointed to the difference in responsibility of the graduate staff nurses in small and large hospitals. In the small hospital, Miss Erickson said, the nurse has no constant medical supervision from interns and residents and is therefore responsible for medical observations and interpretations of patients' conditions to a greater degree than is the staff nurse in a larger hospital.

In addition to Dr. Hinenburg, officers elected by the association were: first vice president, Lawrence E. Kresge, Auburn, N. Y.; second vice president, Bernard McDermott; treasurer, Moir P. Tanner, Children's Hospital, Buffalo; secretary, Carl P. Wright, Syracuse; trustees, Msgr. John J. Bingham, Harold A. Grimm, John H. Hayes, Dorothy Pellenz, Thomas Hale Jr., M.D., Lee B. Mailler, John F. McCormack.

Freezes Social Security Tax

WASHINGTON, D. C.—A House ways and means subcommittee approved June 3 legislation which freezes the Social Security tax at the present 1 per cent each on employes and employers. Under the present law, the tax will automatically rise next January 1 to 2.5 per cent each, unless the proposed "freeze" goes through. The subcommittee may recommend an increase to 1.5 per cent against employe and employer to take place in 1950 and continue at that rate through 1956, after which it would be permitted to rise to 2 per cent.

Regulations Changed for Hospital Survey and Construction Act

WASHINGTON, D. C.—Amendments to the regulations required by the Hospital Survey and Construction Act were announced June 5 by the Division of Hospital Facilities, U.S.P.H.S. They cover: *delineation of a base area; assistance for projects where a construction contract has been let; payment schedules; financial assurance for maintenance and operation, and deviations from the required construction standards.*

The definition of a base area now eliminates the federal requirement that the hospital be registered with the American Medical Association and approved by the American College of Surgeons. (Standards for maintenance and operation are each state's responsibility.) Moreover, it is specified that a base area may be one which does not now have a 200 bed general hospital but will have one upon completion of this program.

Formerly, where the contract for a construction project had been let before the application for federal funds was submitted, the regulation required that a whole new contract be entered into before approval could be given the application. Now, the regulations permit a project to be "picked up" at the stage of completion reached on the date of application. No new contract is required.

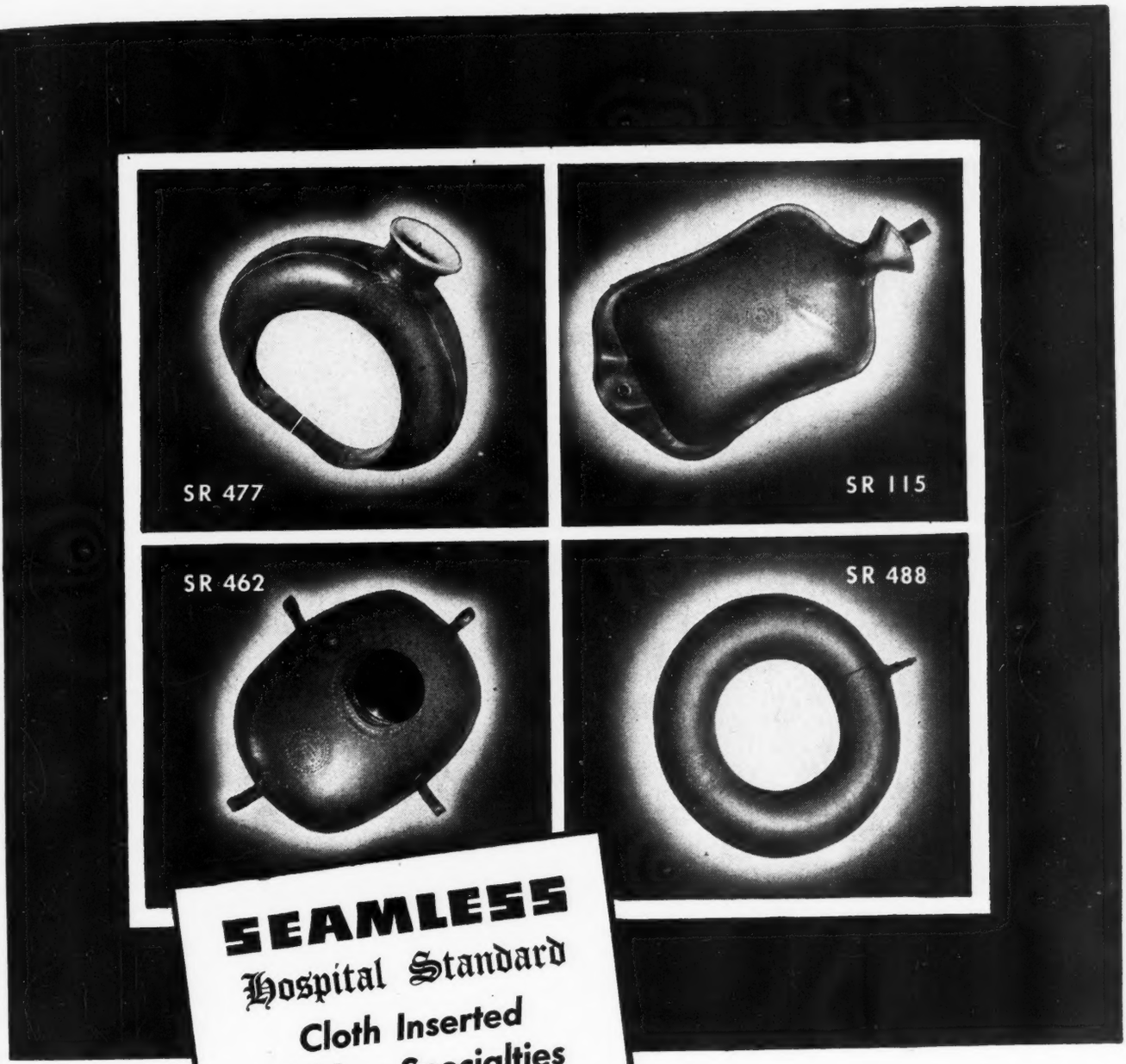
The payment schedule has been liberalized with the time advanced when the first request for payment may be made. The state agency, with the consent of the surgeon general, is now permitted to adopt a different schedule of payments, if desired.

The requirements as to financial assurance for maintenance and operation have been revised but they still specify that an applicant must present a proposed operating budget for a two year period. An operating reserve is no longer required.

In Appendix A, a sentence has been added that permits the surgeon general to waive minor failures to meet the requirements to Appendix A in detail when the project as a whole is in substantial compliance with the prescribed standards of construction and equipment.

Oregon Construction Approved

WASHINGTON, D. C.—An application of the Oregon State Board of Control to construct a new unit of the state hospital for mental patients at Salem has been approved by the facilities review committee of the Office of the Housing Expediter. Approval was on the basis of public safety. The new unit will be built at an estimated cost of $1,508,485.



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Safeguarding the Patient Is Theme of Two Day Maine Hospital Meeting

POLAND SPRING, ME.—With "Safeguarding the Patient" as the theme of its annual meeting held this year at Poland Spring, the Maine Hospital Association proceeded to consider such phases of the subject as professional nursing care, value and use of clinical records and changing conceptions of preoperative and postoperative care.

The need for higher medical standards in smaller hospitals was emphasized by Dr. Roy Crosby, chief of the resident staff, Eastern Maine General Hospital, Bangor. Too frequently, according to Dr. Crosby, almost anyone with an M.D. is allowed to do any type of surgery. The rural hospital, in particular, has need to make specialty services available to all patients through a consulting service with medical teaching centers. Dr. Crosby advocated a rotating resident and intern setup from large medical centers through rural areas so that all small and medium sized hospitals may have the benefit of interns and residents. Thus, the patient will gain through the best of medical science, the local doctor will gain because of better education and the hospital will gain through greater community respect and patronage.

The professional nurse is doing far too many jobs that are not directly connected with nursing care is the contention of Florence Flores, R.N., director of nursing, Massachusetts Memorial Hospital, Boston. Miss Flores' objection is not based on the registered nurse's doing menial tasks but because of the waste of her time with fewer hours available for direct patient care. Among other suggestions she urged hospitals to recruit, train and use more auxiliary workers.



Left to right: Frank C. Curran; Pearl R. Fisher; Louette MacLeod; Dana Thompson.

The physician benefits most or loses most from good or bad medical records. This point was emphasized by Dr. Dexter Elsmore, Rumford Community Hospital, Rumford. In this connection he urged the use of photographs as part of the medical records. These often show facts more clearly than do any written descriptions. It is necessary to keep hammering away to make staffs more record conscious.

Present day emphasis is on proper diagnosis of preoperative and postoperative care. Dr. James Parker, Maine General Hospital, Portland, explained that frequently men with just ordinary skill in technic but with keen diagnostic ability will turn out more cures and do better surgery than will men with only superior technic and manual skill. Dr. Parker proceeded to discuss the extensive use of transfusion therapy as developed by the army and navy during the war.

In describing progress made during the last year, Dr. Stephen S. Brown, president of the association, discussed the need for large payments from Blue Cross so as to pay each hospital its full cost per patient day. He recommended that the Maine Hospital Association appoint a committee on Blue Cross relations to work out mutual problems with Blue Cross members. In commenting on the nursing problem, he stated that unless nursing leaders call a halt to advancing educational standards, many small and medium sized hospitals must close their schools.

Trustees' Responsibility

Considerable discussion centered around the trustees' responsibility in safeguarding the patient. Richard D. Hall, trustee, Thayer Hospital, Waterville, following a talk by Raymond P. Sloan, editor of The MODERN HOSPITAL, urged an educational program for lay trustees, suggesting that a statement be placed in their hands outlining reasons for and the operations of each department in the hospital. The fact that the administrator is or should be the executive head of the institution was stressed by Edward N. Merrill, trustee, Redington Memorial Hospital, Skowhegan, and Samuel Stewart, chairman of trustees, Central Maine General Hospital, Lewiston.

Much attention was focused upon problems attending upon the nursing situation. Dr. Charles Wilinsky, director, Beth Israel Hospital, Boston, emphasized the need for stimulating nursing enrollment. "Among the various suggestions offered to bring this about," he stated, "are higher salaries, shorter working hours, waiver of tuition fees when necessary, and the possibility of reimbursement to the student nurse for the period she is in training. The stimulating of student enrollment involves the education of the public, the waging of intelligent enrollment campaigns, the cooperation of our high schools, women's clubs and federations, the use of the

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press, the radio and the printed word."

Speaking from the standpoint of the small hospital, Helen Goodwin, superintendent, Rumford Community Hospital, Rumford, pointed to the need of proper physical layout and adequate equipment to save nurses' time. "It is poor economy in both time and money," stated Miss Goodwin, "to have nurses and other highly paid professional personnel spending a part of their time running errands to the pharmacy, laboratory, admitting office and other points, making up supplies and doing clerical work. The small training school," she believes, "if well administered by qualified personnel and provided that the student is not exploited, has a definite place and provides a fine service to the people of a rural community. If the school is discontinued the small hospital may continue to lend good service by means of an affiliation as a small, community or rural facility with some larger hospital or college."

Others appearing on the program were: Dr. J. R. McGibony, assistant chief, Division of Hospital Facilities, U. S. Public Health Service, who described the small hospital in the nation's hospital program, and Dr. Frederick T. Hill, medical director, Thayer Hospital, Waterville, who outlined the status of the hospital construction program in Maine. A summarization of the points made by various speakers during the two day session was presented by Everett W. Jones, vice president, The Modern Hospital Publishing Company.

Newly elected officers for the coming year were: president, Frank C. Curran, director, Eastern Maine General Hospital, Bangor; vice president, Pearl R. Fisher, administrator, Thayer Hospital, Waterville, and secretary, Louette MacLeod, superintendent, Camden Community Hospital, Camden.

Daughety Resigns as Texas Association Head

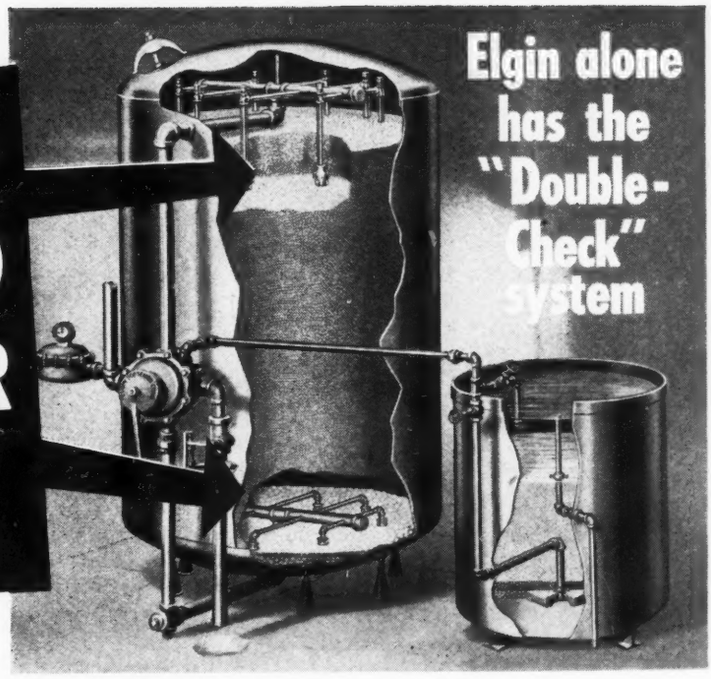
DALLAS.—Because of increased duties at his hospital in connection with an extensive building program, R. O. Daughety, Hermann Hospital, Houston, Tex., has resigned as president-elect of the Texas Hospital Association, it was announced last month. C. J. Hollingsworth, administrator of the West Texas Hospital at Lubbock, was named president-elect by the board of trustees for the remainder of Mr. Daughety's term. Mr. Hollingsworth had been elected vice president of the association during its annual convention in March.

Roy Wilmesmeier, administrator, Southern Pacific Hospital, Houston, was elected vice president.

The trustees announced that the 1948 convention of the association will be held in Dallas March 4, 5 and 6.

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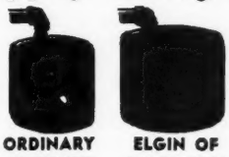
In hospitals, probably the number one use for soft water is in the laundry. But why stop there? In the boiler room soft water stops the scale and lime, cuts boiler cleaning and maintenance. In hot water piping and heaters it prevents hard water deposits, cutting maintenance and replacement costs. In sterilizers it prevents hard water damage, eliminates objectionable deposits on instruments. It makes dishwashing easy — assures clean, sparkling dishes and silver. Throughout the hospital it means easier cleaning, better cleaning, makes everything spic and span as it should look in a hospital. Soap and cleanser costs are cut in half. Remember: Elgin gives you this *extra* soft water at far lower cost per gallon!

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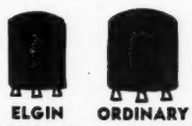
(1) Up to 44% more soft water: By preventing escape of zeolite, the "Double-Check" manifold system permits utilizing a zeolite bed far deeper in proportion to the size of the softener. Likewise, by preventing escape of zeolite, a higher back-washing rate is made possible. The zeolite is kept clean and active, thus more zero-soft water is produced per pound of salt. For example, a 48″ x 72″ Elgin, softening ten-grain water, delivered 21,000 gallons more soft water per regeneration than a conventional softener of identical size.



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New Jersey Group Names Wortman President-Elect

ATLANTIC CITY.—Hospitals must be in a position to prove their costs and make them convincing to the public and government agencies alike. Furthermore, closer relationships should exist between voluntary hospitals and officers of local government, working through councils or committees.

These points were brought to the attention of members of the New Jersey Hospital Association attending the twenty-third annual convention held May 15-17 in Atlantic City by Alexander M. MacNicol, certified accountant and partner, Greenman, MacNicol & Company, New York, and Anthony S. Gadek, member, Board of Freeholders, County of Middlesex, New Jersey.

One million persons, that is, one out of every four in the state, are now Blue Cross subscribers, according to J. Albert Durgom, executive director, Hospital Service Plan of New Jersey, Newark, which substantial increase has resulted in higher subsidies to member hospitals. It was agreed, however, that the public must be told the cost of hospital service, that there should be greater uniformity in determining hospital costs and that hospitals must receive the full cost of patient care either by individuals or from agencies.

New Jersey is short some 1200 nurses, J. Harold Johnston, executive director of the association, told the group. Thirty-five hospitals reported that they would like to hire a total of 449 nurses, and 11 hospitals reported a total of 227 beds closed because of the nursing shortage. In consequence, a renewed emphasis upon a recruiting program for student nurses was recommended.

Concepts for the hospital trustee were indicated by the Hon. Arthur W. Lewis, trustee, West Jersey Hospital, Camden, who, speaking from the point of view of the public, urged the need of greater knowledge on the part of the trustee of his precise function and his obligation as public servant.

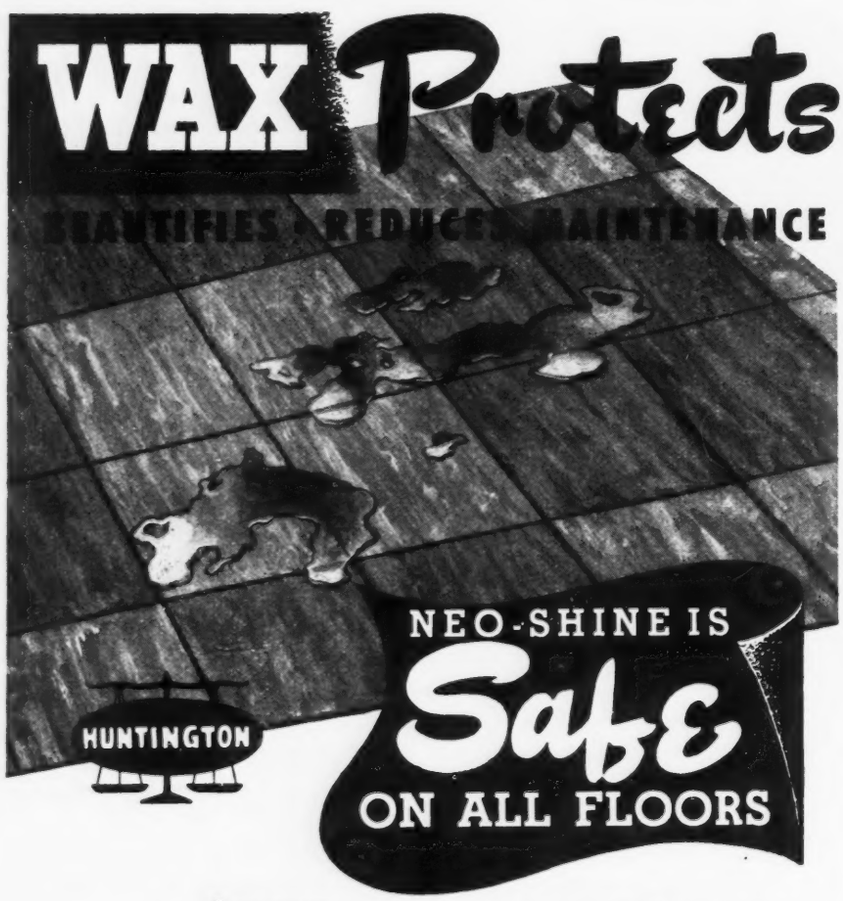
There are definite reasons, according to Dr. Edward H. Willan, chief of staff and member of the board of trustees, East Orange General Hospital, why doctors can render valuable service on the boards of voluntary institutions. M. H. Teaze, past president and trustee, Mountainside Hospital, Montclair, explained what the hospital administrator has a right to expect of his hospital trustee. Russell P. Dey, trustee, William McKinley Memorial Hospital, Trenton, served as chairman of the Trustees' Session and a period of discussion followed, led by Raymond P. Sloan, editor, THE MODERN HOSPITAL.

Personnel practice engaged the attention of the association during one session at which an explanation of the 40 hour week was presented by William J. Donnelly, director, Greenwich Hospital, Greenwich, Conn. Policies pertaining to vacation and sick leaves were outlined by George Peck, administrator, Jewish Hospital, Philadelphia.

For the first time in the history of the association a hospital trustee was elected as officer. Russell P. Dey becomes first vice president for the new year. George H. Buck, superintendent, Mercer Hospital, Trenton, succeeds Frank B. Gail, as president and Dr. Herbert M. Wortman, director, Mountainside Hospital, Montclair, becomes president-elect. Thomas J. Golden, assistant to the director, Medical Center, Jersey City, continues as treasurer.

U.H.F. Honors Aides

NEW YORK.—More than 1200 men and women volunteers serving in voluntary and municipal hospitals since the end of the war received awards from the United Hospital Fund at a special ceremony last month. "If it had not been for the loyal and devoted service that you gave us our hospitals would not have survived," the city commissioner of hospitals told the volunteers. The awards were presented by Charles D. Halsey.

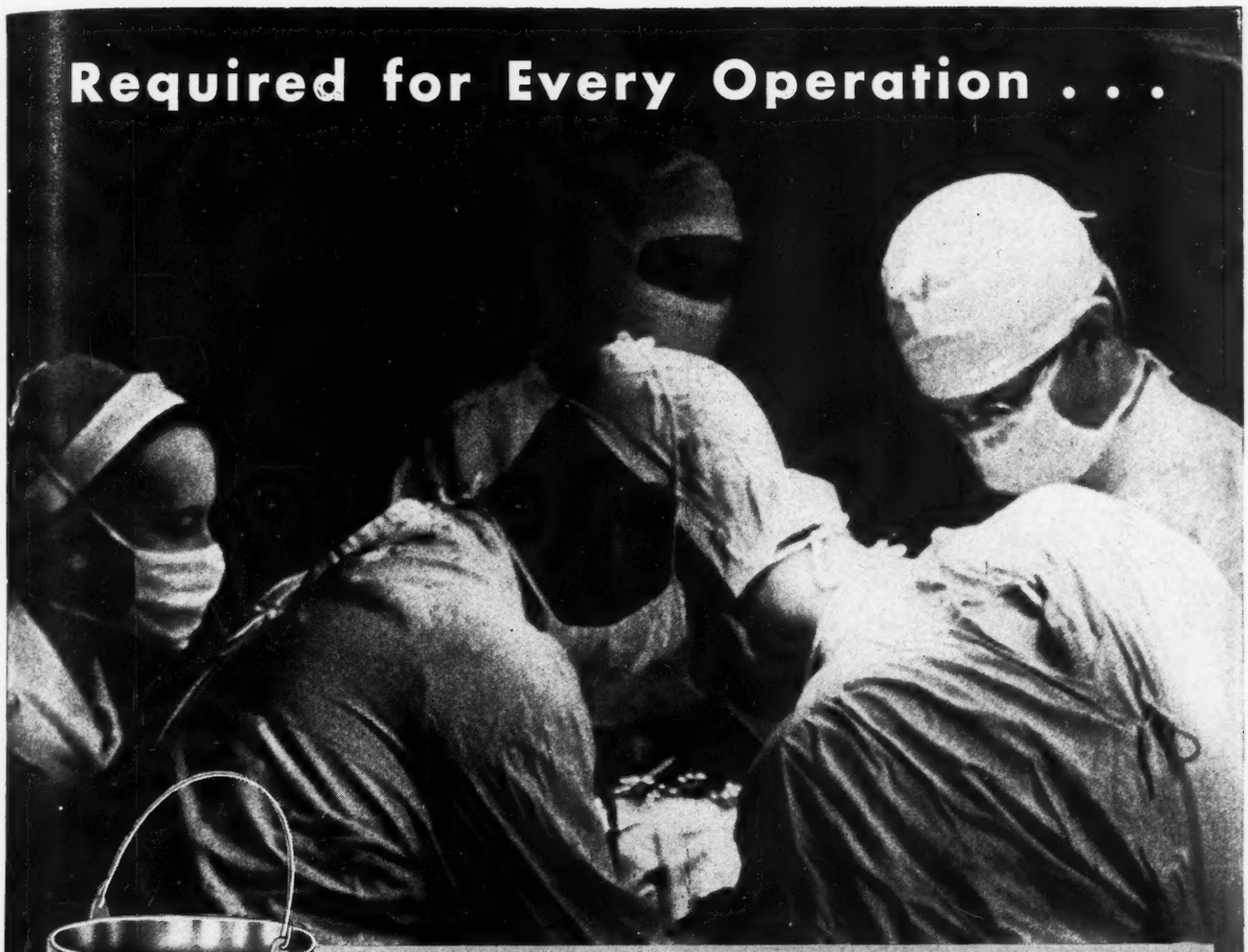


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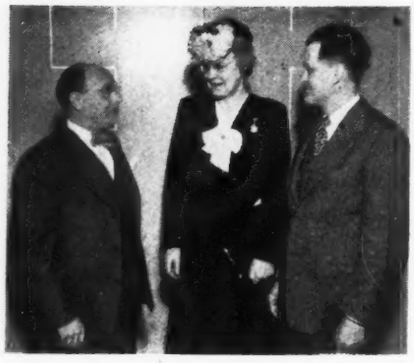
UTENSILS OF DURABILITY AND ECONOMY

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Nurse Shortage Holds Spotlight at Minnesota Hospital Convention

MINNEAPOLIS—The main problem confronting hospitals today is a lack of skilled personnel, especially nurses, and administrators must discover some means of solving this problem as swiftly as possible if they hope to maintain adequate care for their patients.

This was the major consideration which emerged from the twenty-fourth annual convention of the Minnesota Hospital Association in Minneapolis, May 15, 16 and 17.



Left to right: Award winner Earl Wolf; Presidents Nellie Gorgas and Emil Hansen.

George Bugbee, executive director of the American Hospital Association, opened the convention with a discussion of the national problems confronting hospitals, in which he pointed out that "demands for hospital care are running in excess of supply, and with hospital costs up more than 60 per cent and the shortage of skilled personnel, hospital administrators must worry about getting along with what they have before they can think of expanding."

He aso stated that one of the greatest problems facing hospitals is that of interesting more people in hospital work.

Other convention speakers included Mayor Hubert H. Humphrey of Minneapolis; Alec Ford, Pacific Mills, New York City, who spoke on the "Procurement of Textiles," and Robert N. McMurry, who spoke on "Human Relations in Employment." Mr. McMurry, president of Robert N. McMurry and Company, Chicago, is an industrial relations counselor.

To Counteract Dissatisfaction

In line with Mr. Bugbee's statements concerning hospital personnel, Mr. McMurry declared that personnel selection is the biggest problem of the hospitals, just as it is in industry. Pointing out that even though hospital salaries have gone up at least 100 per cent there is still dissatisfaction among personnel, he suggested that hospitals counteract this dissatisfaction by doing the following:

1. Try to put the right personnel in the right job.
2. Set up a testing method for employes to be certain they are in the right position.
3. Give new employes some orientation, see that they get acquainted with the surroundings and other employes.
4. Give employes recognition so they can be proud of their jobs.
5. Set up an efficient outlet for employes' grievances.

"Hospital Accounting" was discussed by Leslie Reid, director, Presbyterian Hospital, Chicago, and Ella May Thompson, R.N., National Association for Practical Nurse Education, spoke on "Practical Nurse Education and Service."

A temporary solution to the problem of providing more room for patients was announced by Richard K. Fox, assistant superintendent, St. Luke's Hospital, Duluth. Mr. Fox described the use of Quonset huts at St. Luke's to house an overflow of patients, declaring that it is a satisfactory and quick means of expanding hospital facilities until actual buildings or additions can be made ready.

The Minneapolis *Star* and *Tribune* presented a leadership plaque to Earl Wolf, retiring president of the association, and to the Minnesota Hospital Association itself for its being one of the

RUN IT ONCE...
and Sweep up the ROACHES!

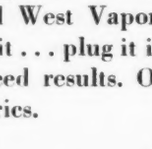


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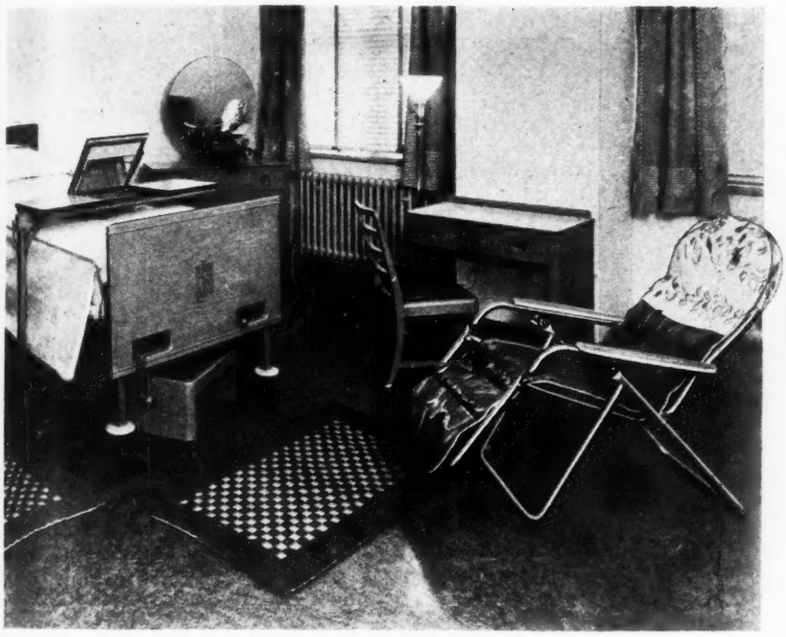


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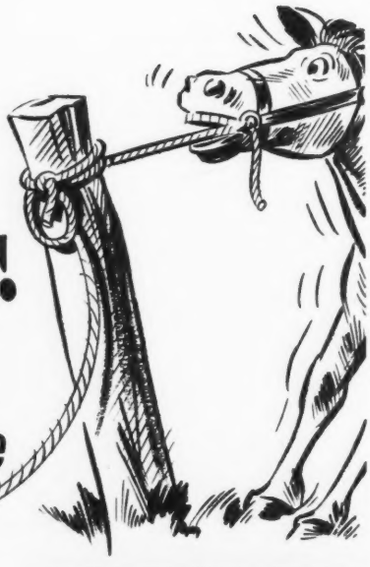
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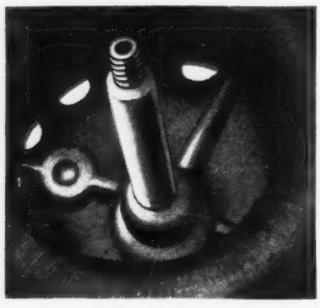
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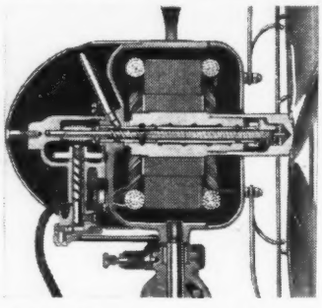
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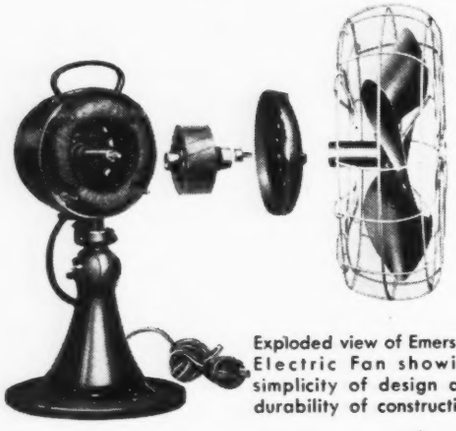
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most progressive groups in the state and for its noteworthy pioneering in the hospital and health fields.

New officers of the Minnesota Hospital Association, elected at the convention, are as follows: president-elect, Emil Hansen, Winona General Hospital, Winona; first vice president, R. K. Swanson, Swedish Hospital, Minneapolis; second vice president, Helen Eyk, Montevideo General Hospital, and treasurer, Richard K. Fox, business manager, St. Luke's Hospital, Duluth. New members elected to the board of directors are Sister M. Thomasine, St. Francis Hospital, Breckenridge, 1947-50, and John M. Alexon, Virginia Municipal Hospital, Virginia, 1947-49.

Nellie Gorgas, St. Barnabas Hospital, Minneapolis, who was president-elect this last year, is now president of the Minnesota association.

Arkansas Association Names New Officers

LITTLE ROCK.—Marvin H. Altman, administrator of Spark's Memorial Hospital, Fort Smith, Ark., was named president elect of the Arkansas Hospital Association at the annual meeting in Little Rock last month. Moody Moore of Little Rock, supervisor of the hospital



Left to right: President Moody Moore; president-elect, Marvin H. Altman; vice president, Tom England; secretary, R. C. Warren.

division of the Arkansas State Health Department, became the association's president at the meeting.

Other officers elected were: vice president, Tom England, Helena Hospital, Helena; secretary, R. C. Warren, Davis Hospital, Pine Bluff; treasurer, Sister Mary Margaret, Warner-Brown Hospital, El Dorado.

Griffin Heads Catholic Group

BOSTON.—Msgr. Maurice F. Griffin of St. Philomena's Church, Cleveland, was elected president of the Catholic Hospital Association of the United States and Canada at its thirty-second annual convention June 18. Rev. John W. Barrett, director of Catholic hospitals for the archdiocese of Chicago, was named first vice president of the association. Further details of the association's convention which was still being held as this issue of THE MODERN HOSPITAL went to press will be found in next month's magazine.



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Eva H. Erickson Named Winner of MacEachern Medal



CHICAGO.—Eva H. Erickson, administrator of the Olean Genera Hospital at Olean, N. Y., was awarded the Malcolm T. MacEachern medal as the outstanding member of the graduating group in the hospital administration program at Northwestern University in Chicago, June 18. The award is made annually for "high standing and unusual promise of achievement in the profession of hospital administration." Dr. Henry G. Farish of the American College of Surgeons' staff received the medal for second honors, and a special medal for outstanding work by a foreign student was awarded to Jorge Soto-Rivera of Venezuela.

Thirteen students received the master's degree in hospital administration and five, the bachelor of science degree in hospital administration at the Northwestern University commencement.

In addition to the award winners,





L.: Dr. Henry Farish; R.: Jorge Soto-Rivera.

members of the graduating group were Theodore A. Austin, Delbert Bouck, Daniel M. Brown, Paul M. Cole, Eloise B. Furnival, Nicholas A. Herrig, Betty Hull, Rex J. Krohn, Sheldon A. Miller, Roma Philbrook, Leon C. Pullen, James T. Richards, Stanley R. Schulman, J. Walsh Stull, Agnes S. Watty.



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Army Medical Corps Extends Deadline

WASHINGTON, D. C.—The deadline for applications of all officers and former officers of the medical and dental corps of the army for regular army commissions has been extended to July 31. The additional application period was given in an effort to obtain more medical candidates for regular army commissions. The number of medical officers brought into the army in 1947 falls far below the desired proportion, according to the Office of the Surgeon General.

Any medical or dental officer who is now on active duty or who saw service with the army during World War II will be eligible to submit his application to the Adjutant General. Applicants are limited to those qualified in certain specialties.

Pay increases for army and navy medical personnel were advocated recently by Secretaries Patterson and Forrestal before the armed services committee of the House. According to Mr. Forrestal, the navy will be 65 per cent short of its estimated requirements when reserve officers, now on duty, are released. Mr. Patterson declared that the army had only one applicant for every three medical officer vacancies.

Blue Cross Conference

CHICAGO.—The second annual public relations conference of Blue Cross plans and coordinated medical-surgical plans will be held in Chicago July 17 and 18, Richard M. Jones, director of the Blue Cross Commission for the American Hospital Association, announced this month. Stanley H. Saunders, chairman of the commission's public relations committee, will be chairman of the conference at which public relations executives of Blue Cross and industry will appear.



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A.M.A. President Urges Committee to Study Nursing Problems

ATLANTIC CITY.—Formation of a committee to investigate nursing objectives, educational standards, services and economics was urged on the house of delegates of the American Medical Association during the association's centennial celebration last month. More than 15,000 physicians were registered for the convention, largest in the association's history.

The proposal for a nursing study was made by Dr. Edward L. Bortz of Philadelphia who became president of the association during the convention.

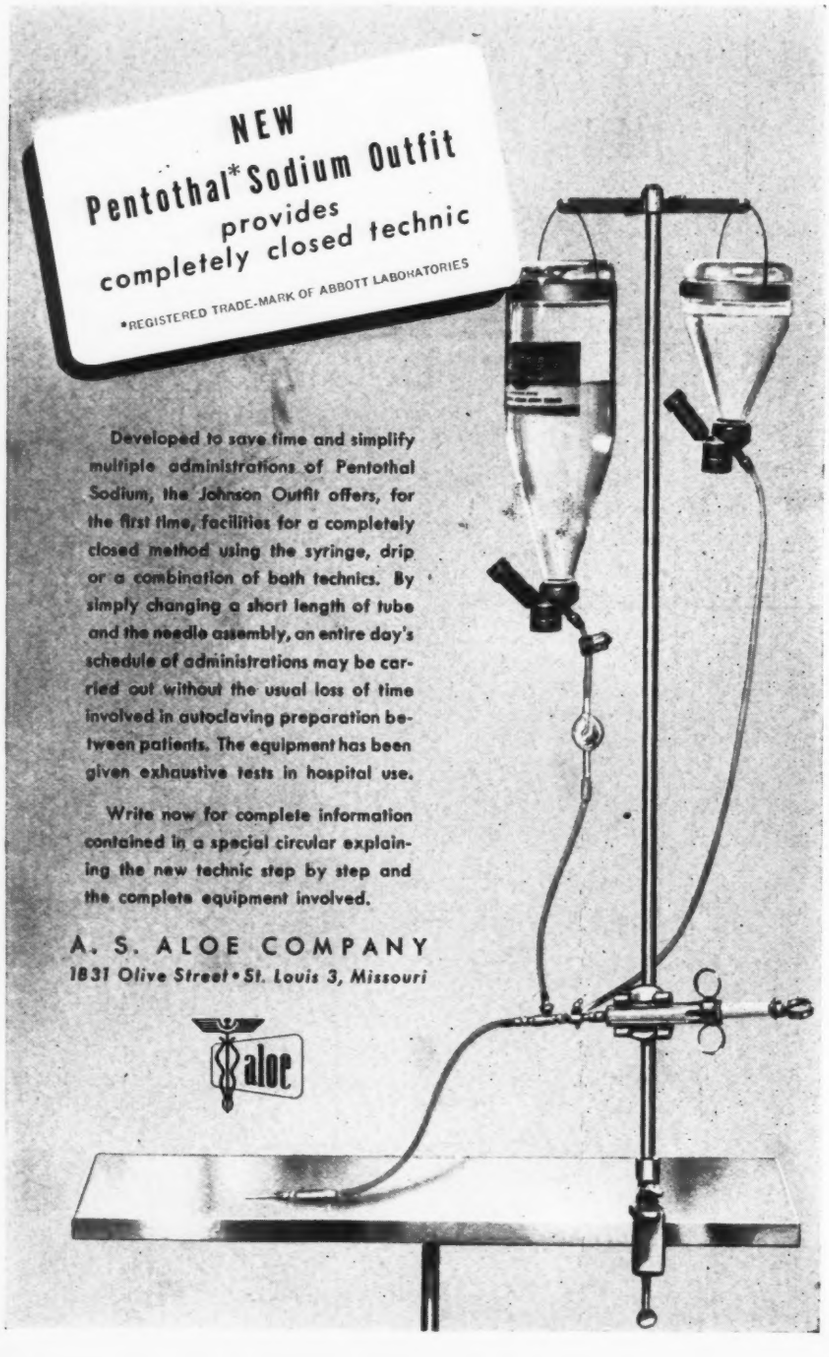
"Within the past few years a serious crisis has developed in the nursing field," Dr. Bortz told the delegates. "It must be admitted that the nurses have many real grievances today. The status of the private duty nurse and the general floor nurses in the hospitals is unsatisfactory. Long hours, irregular employment, lack of any pension or security program and indifference on the part of groups which should be cognizant of the nurses' needs have caused a serious shortage in one of the noblest of the nation's professions. It is high time that physicians study the ramifications of these issues and exert their influence in support of the objectives which members of the nursing profession are now striving to attain."

Dr. Bortz also urged study looking toward affiliation with the association of third and fourth year medical students. "This group should be brought into the medical family at the earliest possible time and given the privilege of more active participation in the association," Dr. Bortz declared. "From this group will come the physicians of the future. Indifference on the part of the association to this group may be corrected by affiliate membership, reestablishment of a student section in the *Journal* and encouragement of presentation of scientific papers. Medicine should recognize the coming generation. The benefits to be derived from bringing them into closer contact with organizational activities should develop leaders at an early stage in the professional careers of medical practitioners."

Dr. Harrison H. Shoulders of Nashville, Tenn., retiring president, recommended organization of a committee to study broad needs in medical education today. Specifically, Dr. Shoulders pointed to the need for clarification of the functions of the general practitioner, determining the extent to which medical education facilities should be expanded, studying the feasibility of utilizing small community hospitals in the training of general practitioners and studying means by which communities in need of additional medical service may best be aided.

Dr. Roscoe L. Sensenich of South Bend, Ind., who has been a member of the A.M.A. board of trustees for the last ten years, was named president-elect.

Raymond T. Rich of New York resigned as public relations counselor to the association and Charles Swart of Chicago resigned as public relations director on the headquarters staff.



W.A.A. Seeks Bids on Sulfanilamide Crystals

WASHINGTON, D. C.—About two million packages of sulfanilamide crystals, each containing 5 Gms., are being offered by War Assets Administration in a competitive bid offering closing at 5 p.m. July 14. Reported cost of the crystals is about $100,000.

Bids are to be submitted directly to the Director, Medical Sales Division, W.A.A., Washington 25, D. C. Priority buyers may submit orders to buy at fair value, which will be determined by bids of other buyers. The minimum bid considered must total 50,000 packages.

The crystals are packed in sterile, sealed paper envelopes and have been tested and found to be in excellent condition.

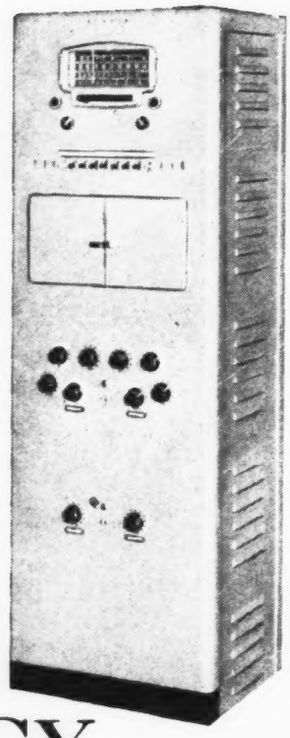


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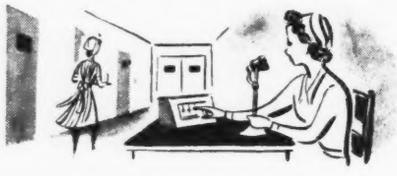
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Compulsory Health Insurance Argued on "Times" Radio Forum

NEW YORK.—The national health program and particularly a national compulsory insurance plan were discussed on a *New York Times* radio forum last month. Participants were: Dr. Ernst P. Boas, chairman of the Physicians' Forum, Michael M. Davis of the Committee for the Nation's Health who favored a national health plan, Louis H. Pink, president of Associated Hospital Service of New York, and Dr. Ethel E. Wortis, chairman of the public health committee of the Women's City Club, who advocated a voluntary program.

Dr. Pink supported the S. 545, Taft-Smith-Ball-Donnell bill, now under consideration in Congress, as a proper solution to the problem of providing medical care for the needy. The proper responsibility of the federal government, he said, was to expand public health service and provide financial aid to states needing assistance in medical and hospital programs. His views were supported by Dr. Wortis who said that Americans do not appreciate the extent to which voluntary health insurance has already solved the nation's medical care problems. Approximately 45,000,000 people are protected by some kind of hospital or medical insurance, Dr. Wortis said.

Dr. Davis maintained that voluntary plans do not reach enough persons and do not provide enough service. "We need a nationwide system of health insurance which would collect what people now pay for medical bills and pool it into a national fund," Dr. Davis declared. "On that basis we shall be able to maintain hospitals and attract hospital staffs and doctors to the poorest parts of the country."

"The time has come when health and medical care are as much a right of citizenship as is the right to education," Dr. Boas concluded.

Torchlight Parade Opens Drive

NEW YORK.—Opening of a campaign for $5,000,000 for the New York Infirmary Medical Center building fund was marked by an old fashioned torchlight parade on Fifth Avenue last month. An estimated 200,000 people lined the curbs to watch the parade in which Hollywood and Broadway personalities participated along with other celebrities from the political and business community. Floats in the parade told the history of the New York Infirmary, founded 94 years ago. The parade was climaxed by a meeting in Madison Square Garden at which appeals for support of the hospital were made.



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A.H.A. Plans Institutes Covering Various Phases of Administration

CHICAGO.—Institutes covering several different phases of hospital administration will be sponsored during the summer months by the American Hospital Association and various affiliated organizations, according to an announcement made at the association's headquarters. Among the institute programs which have been planned are:

1. An institute on the theory and practice of cost analysis to be held July 21 to 25 at Indiana University, Bloomington, Ind. Basic cost concepts and the three generally accepted methods of cost analysis will be presented with particular emphasis on application of cost methods to various operating functions and problems. Registration will be limited to 75 members who must be personal members of the association or authorized representatives of institutional members.

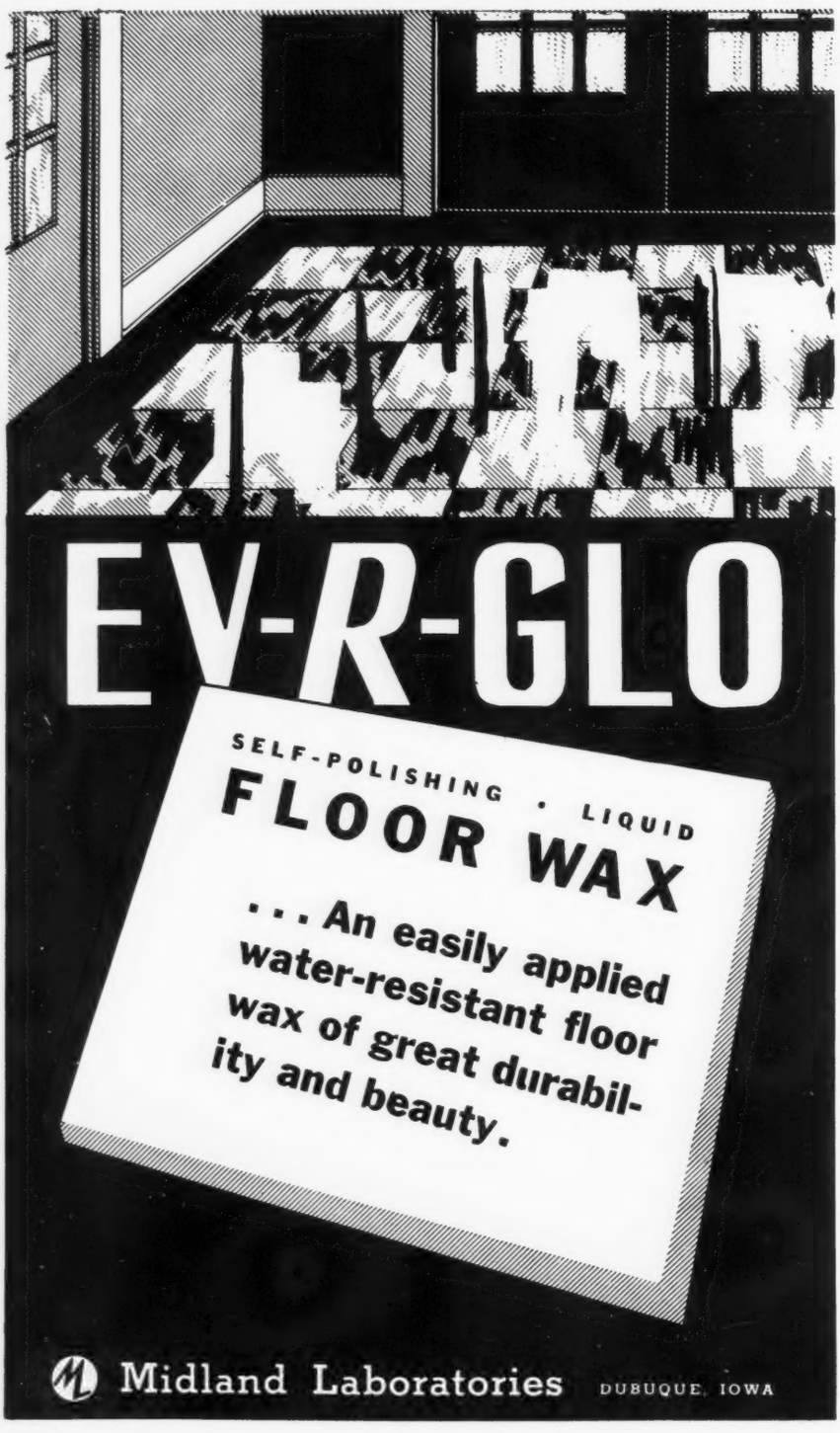
2. A conference to promote the development of better public relations by hospitals scheduled for July 28 and 29 in Madison, Wis., in cooperation with the school of journalism of the University of Wisconsin and the Wisconsin Hospital Association. Topics to be discussed include the community's view of the hospital, need for better planned public relations programs, mechanics of public relations, internal public relations, public opinion surveys and cooperation with community groups. Registration will be limited to 75 hospital administrators and public relations workers.

3. An institute on hospital personnel management to be held in Cleveland, August 4 to 8, in conjunction with the Cleveland Hospital Council and Western Reserve University. Study subjects include means of improving morale, increasing efficiency and utilizing employe skills. Registration limited to 100 hospital administrators, assistants and personnel directors.

4. An institute on hospital planning to be held in Chicago, August 18 to 22, providing background information which will be helpful to administrators in their contacts with various experts on planning and construction. Subjects to be covered include advance organization, planning patient and service areas, building details, elasticity and provision for future expansion, requirements for nursing and patients, fire safety, selection of architect and planning specific service departments. One session will be devoted to discussion of the federal hospital construction and survey program. Registration will be restricted to 100 administrators and other officials.

5. An institute on advanced accounting to be conducted at Tulane University, New Orleans, August 25 to 29, in conjunction with the Louisiana Hospital Association, the New Orleans Hospital Council and the Louisiana Association of Hospital Accountants. Topics include theory of fund accounting, budgeting, cost analysis, principles of insurance and public relations for the accounting executive. Registration limited to 100 administrators, business managers and hospital accountants.

6. An institute on nursing to be held in Chicago August 25 to 29 under the joint sponsorship of the A.H.A. and the National League of Nursing Education. Hospital administrators, physicians, nursing school directors and other educators will discuss the requirements for administration of nursing schools, the rôle of auxiliary workers in hospital nursing, nursing school curriculum and organization and financing of nursing education generally. Enrollment limited to 50 hospital administrators and 50 nursing school directors.



Boston Organizes Eye Bank

NEW YORK.—An eye bank has been organized in Boston and is ready to serve the needs of New England, it was announced in May at national headquarters of the Eye-Bank for Sight Restoration, Inc., which celebrated its second anniversary last month.



FOR TRUSTED HANDS

Hands that have shown their trustworthiness in many a complicated operation and countless routine tasks deserve a trustworthy antiseptic. Zephiran chloride has proved its worth in thousands of surgical cases as a safe and reliable agent that is nonirritating to skin, mucous membranes and wound tissues in effective dilutions. Zephiran chloride leaves hands soft and smooth. Furthermore, Zephiran chloride is very economical: 1 oz. of the concentrate makes 1 gal. of the most commonly used 1:1000 solution. . . . . Aqueous Solution 1:1000, Stainless Tincture 1:1000 and Tinted Tincture 1:1000, bottles of 8 oz. and 1 gal. Concentrated 12.8% Aqueous Solution, bottles of 4 oz. and 1 gal.

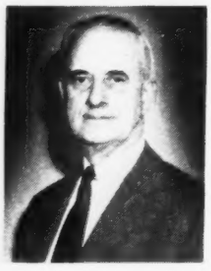


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Murray Sargent Heads Greater New York Hospital Association



NEW YORK.—Murray Sargent, director of New York Hospital, was elected president of the Greater New York Hospital Association at the annual meeting last month.

Other officers elected were: first vice president, Louis Schenkweiler, superintendent, Wyckoff Heights Hospital; second vice president, Rev. J. J. Curry, assistant director, division of health, Catholic Charities; secretary, F. Wilson Keller, superintendent, Hospital for Special Surgery; treasurer, Louis Miller, superintendent, Jewish Memorial Hospital.

Members of the executive committee are: Dr. S. L. Friedman, executive director, Sydenham Hospital; Dr. A. A. Karan, superintendent, Bronx Hospital; Dr. Karl Klicka, superintendent, Woman's Hospital; John S. Parke, executive vice president, Presbyterian Hospital; Rev. C. O. Pedersen, superintendent, Norwegian Lutheran Deaconesses' Home and Hospital, and Dr. W. B. Talbot, superintendent, New York Post-Graduate Hospital.

Rev. C. O. Pedersen, retiring president, outlined the accomplishments of the association during the past year to 200 delegates from 97 voluntary, nonprofit hospitals and 22 municipal hospitals in the greater New York area.

Announce Fund Campaign

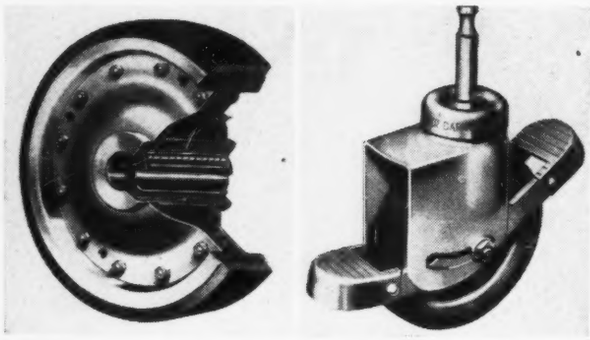
TROY, N. Y.—A campaign to raise funds for modernization of the Troy Hospital was announced last month by Sister Mary Angela, administrator. The program includes remodeling of the operating room suite, replacement of elevator, laundry and power plant equipment, refurnishing of several hospital departments and the construction of a new nurses' residence.

Springfield Alumni Gather

SPRINGFIELD, MASS.—Several hundred nurses, staff members and alumni of the Springfield Hospital participated in a program last month honoring hospital nurses, staff members and employes who served in the armed forces during World War II. A memorial plaque at the hospital was unveiled during the day's program which also featured exhibits on the history of nursing and medicine. The principal address was made by Dr. J. Graham Bruce of the hospital staff.

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All Darnell Institutional Casters and Wheels are made to meet the most exacting requirements of hospital use.

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COMING MEETINGS

ALBERTA HOSPITAL ASSOCIATION, Edmonton, Alta, Oct. 20-26.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Hotel Commodore, New York City, Sept. 8-12.

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, St. Louis, Sept. 22-25.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Hotel Jefferson, St. Louis, Sept. 20-22.

AMERICAN COLLEGE OF SURGEONS, Clinical Congress, Waldorf-Astoria Hotel, New York City, Sept. 8-12.

AMERICAN CONGRESS OF PHYSICAL MEDICINE, Hotel Radisson, Minneapolis, Sept. 2-6.

AMERICAN DIETETIC ASSOCIATION, Philadelphia, Oct. 13-15.

AMERICAN HOSPITAL ASSOCIATION, St. Louis, Sept. 22-25.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, Hotel Del Coronado, San Diego, Calif., Oct. 3-Nov. 7.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Hotel Jefferson, St. Louis, Sept. 19-21.

AMERICAN PUBLIC HEALTH ASSOCIATION, Atlantic City, N. J., Oct. 6-10.

CANADIAN HOSPITAL COUNCIL, Winnipeg, Man., Oct. 16-18.

NEBRASKA HOSPITAL ASSEMBLY, Fontenelle Hotel, Omaha, Nov. 13-14.

1948

ASSOCIATION OF WESTERN HOSPITALS, Biltmore Hotel, Los Angeles, April 19-22.

TEXAS HOSPITAL ASSOCIATION, Dallas, March 4-6.



Here's convenience, modern design, plus low-cost operation – the *new* 1947 McCray Reach-Ins come in 60, 40, 30, 20 and 12 cu. ft. capacities.

"Not only how good but how fresh!"

... that's the primary consideration, wherever perishable foods are served. And it's of first importance in the planning of the new 1947 McCray KOLDFLO models designed especially for hotels, restaurants, clubs, hospitals and institutions.

McCray Koldflo "Packaged" refrigeration, the compact, single-unit McCray KOLDFLO completely self-contained system, assures that all foods are kept at their peak of freshness ... merchandise is easily visible, readily accessible. Your investment is protected, continued patronage encouraged.

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GO MODERN WITH

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Surgical Tradesmen Predict Firm Prices, Hear Hospitals' Case

HOT SPRINGS, VA.—Prices of equipment and supplies purchased by hospitals are firming and holding steadier and hospital buyers can look in most cases today for a firm price bid with a guarantee on the quoted price, Howard Baer declared at the annual meeting of the American Surgical Trade Association here June 16.

Every possible effort should be made by manufacturers to reduce prices so that hospitals can go forward with necessary purchases for modernization and expansion programs, Mr. Baer said. He urged manufacturers to keep prices as low as possible to encourage volume sales and to keep production costs down.

In a session turned over entirely to hospital people for discussion of their needs and presentation of the hospital point of view to manufacturers, the following objectives were stated by various representatives of the hospital field.

1. Manufacturers should make every conceivable effort to lower prices so that hospitals can purchase needed equipment.

2. Manufacturers should keep in mind the fact that mounting hospital costs are reaching a point which makes it difficult for most people to pay hospital bills.

3. Highly trained service men representing manufacturers in the field should be able to help hospitals reduce operating costs.

4. Manufacturers and dealers were urged to improve advertising policies so as to furnish real educational information for hospital executives.

One of the liveliest sessions of the meeting was a question and answer period on manufacturing problems in which practices such as soliciting building fund donations from manufacturers and providing gifts and entertainment for hospital buyers were condemned. The practice of cooperative purchasing by groups of hospitals was also discussed at considerable length.

Everett W. Jones, vice president of The Modern Hospital Publishing Company and moderator of the questions and answers program, urged the A.S.T.A. to appoint a small committee to prepare a bill enumerating the criticisms and complaints of dealers and manufacturers on hospital purchasing practices. Such a statement, if documented with real evidence, could be used to good advantage in courses in hospital administration, purchasing institutes and purchasing sections at state, regional and national hospital meetings.

Officers of the association for the coming year are as follows: president, William A. Peacock, Peacock Surgical Co., Inc., Shreveport, La.; vice president, W. Sinclair Stewart, Winchester Surgical Supply Company, Charlotte, N. C.; secretary, Fred B. Hovey, American Surgical Trade Association, Chicago, and treasurer, Herbert L. Crowley Sr., Crowley & Gardner, Boston.



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VESTAL ELECTRIC FLOOR MACHINE

Scrubs and polishes FASTER. Easy to operate. Amazingly quiet.



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V.A. Economizes in Use of Doctors, Nurses

WASHINGTON, D. C.—The closing of LaGarde Hospital at New Orleans, announced June 9, follows recent Veterans Administration policy in the consolidation of emergency hospitals to economize in the use of doctors and nurses and to effect more efficient operation. All patients from LaGarde were transferred to the adjacent Naval Hospital taken over by V.A. It is tentatively planned to operate beds for 414 patients there.

The Veterans Administration had earlier ordered the consolidation of three other emergency hospitals and the transfer of 659 patients to better equipped structures. The shift in medical personnel will permit V.A. to open sufficient wards in its larger hospitals to offset the loss in beds.

The three hospitals consolidated are at Sampson, N. Y.; Saratoga Springs, N. Y., and Thomasville, Georgia.

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palatable
easily digested
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Protein-Carbohydrate Granules

Protein therapy is important in all branches of medicine. Every cell of every tissue requires protein for growth and repair. Protein requirements are therefore frequently enormous. • How may protein be administered in large amounts? The simplest and best way is by mouth, for any patient who can swallow. Infusion hazards are avoided; more complete nutrition is provided.* • 'DELCOS' Protein-Carbohydrate Granules present palatable, concentrated, *whole* protein of high biologic value, protected from wasteful use as energy. • Patients like the taste of 'DELCOS' Granules, and will accept it almost ad libitum. Dosage may be pushed to the limit and maintained at a high level indefinitely. Moreover, since 'DELCOS' Granules provide carbohydrate-protected, *whole* protein, containing *strepogenin*,* a factor lacking in protein hydrolysates or mixed amino acids, maximal nutritional efficiency is achieved. Controlled growth tests have shown that 'DELCOS' Granules are biologically superior to beefsteak. • 'DELCOS' Protein-Carbohydrate Granules contain casein and lactalbumin, providing a balanced combination of *all* the essential amino acids, as *whole protein*, protected from wasteful use as energy by carbohydrate (30%). Supplied in 1-lb. and 5-lb., wide-mouthed jars. Sharp & Dohme, Philadelphia 1, Pa.



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*Editorial: J.A.M.A., *131*:826, July 6, 1946.

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• in laundryrooms
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A tough, durable rubber and cord matting with ridged bottom that affords aeration and drainage. Provides safety underfoot. 3/8" thick, 24" wide, any length.

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For prices and folder, "A Mat for Every Purpose" for promoting safety and sanitation and reducing fatigue, write

AMERICAN MAT CORP.
"America's Largest Matting Specialists"
1719 Adams St., Toledo 2, Ohio

Sterilizers, Telephone Equipment Added to 5% Surplus List

WASHINGTON, D. C.—More items have been added to the growing list of surplus property for disposal to eligible public health and educational institutions at 5 per cent of fair value. Sterilizers were recently placed on the nominal price program. Other new items are telephone equipment, miscellaneous communication equipment, hand tools, electronic devices and automobile service station equipment.

An earlier list covered: kitchen cooking appliances; food preparation appliances; punched card, bookkeeping, tabulating and accounting machines; billing machines; adding machines; calculating machines; duplicating machines; cooking and warming equipment, commercial, except electric; household mechanical refrigerator units; commercial reach-in refrigerators, mechanical; office furniture; auditorium furniture; laboratory furniture; laboratory research and testing instruments and apparatus; compound microscopes; surgical and medical instruments, except diagnostic (Japanese instruments only); field hospital food carts; chemical laboratory apparatus; field hospital laboratory incubators; miscellaneous professional and scientific instruments and apparatus; oxygen breathing apparatus; hand fire extinguishers; cooking and kitchen utensils; kitchen tools, except cutlery; table and kitchen cutlery, household and institutional; food processing cutlery; technical and scientific laboratory glassware; china and porcelain laboratory ware; carbon paper; typewriter ribbons, and clinical and infirmary equipment units.

Many of these items, some in plentiful supply, were considered for a donation program, according to W.A.A. officials. Acquisition of this property through the nominal price program or 5 per cent of fair value was considered a better bargain, however, for institutional buyers.

Maryland-D.C. Group Meets

BALTIMORE.—Nursing service and hospital planning were the principal topics for study and discussion at the spring conference of the Maryland-District of Columbia Hospital Association held in Salisbury, Md., May 23 and 24. Among those who took part in the discussions were Leo Schmelzer, George Washington Hospital, Washington, D. C.; Dr. Louis Block, U. S. Public Health Service; Dr. Edwin L. Crosby, Johns Hopkins Hospital; J. G. Capossela, Washington, D. C.; J. D. Colman, Baltimore; Rufus C. Rorem, Philadelphia; A. K. Parris, Baltimore.

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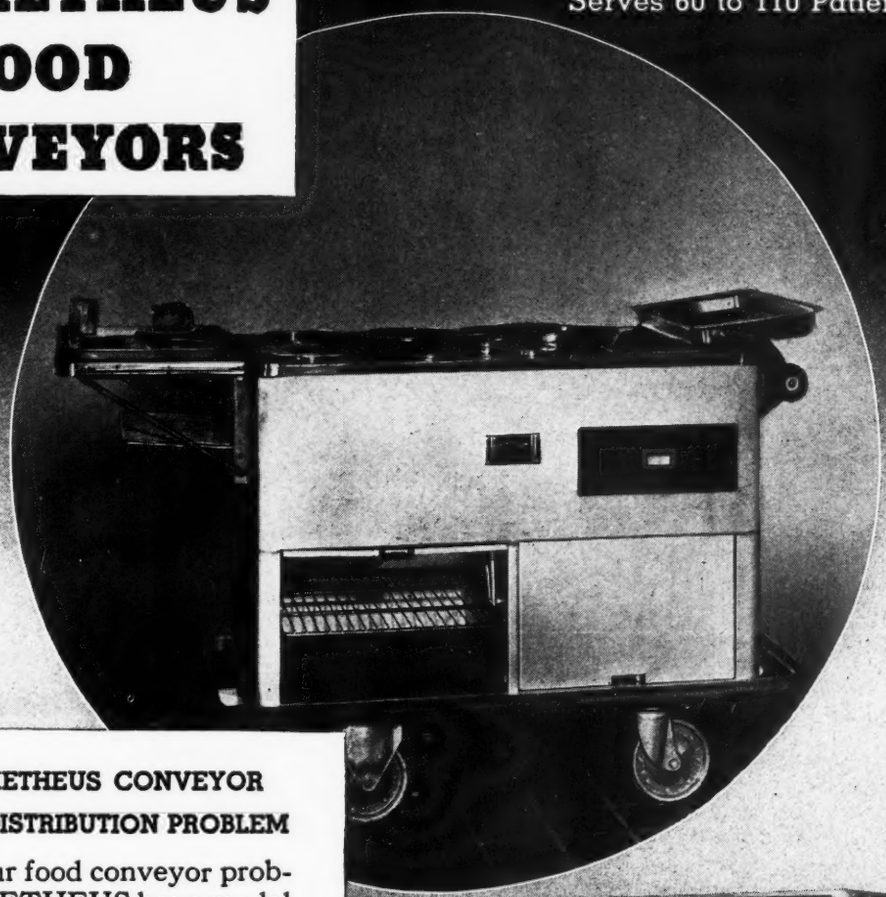
Comparative pH meter tests of various soaps revealing that Softasilk 571 with its unique buffer action releases less alkalinity by hydrolysis will be sent you on request. If you wish, send along a sample of your present soap, and we will conduct a similar test for you without cost or obligation. Write today.

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Standard Model No. 1038
Serves 60 to 110 Patients



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No matter what your food conveyor problem may be, PROMETHEUS has a model to meet your requirements or will design a special conveyor to fill your individual needs. The engineering and manufacturing experience of our organization is at your service for this purpose.

PROMETHEUS conveyors are scientifically designed for greatest efficiency in practical day by day operation. They are strongly built of the finest materials and will give many years of satisfactory service. Backed by 40 years of experience, PROMETHEUS food conveyors have no superior.

PROMETHEUS conveyors are attractive in appearance, compact in size, easy to handle, economical in cost, economical to operate and use a minimum of current. Approved by Underwriters Laboratory.

Send for descriptive circular giving full details of various designs, capacity and special features.



PROMETHEUS electrically heated tray conveyor. For central tray service or special diet service. Sturdily constructed, attractively designed and extremely mobile.

PROMETHEUS tray conveyors offer the perfect solution to many hospital problems of food service.

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Climax in Nurse Recruitment Campaign Comes This Month

CHICAGO.—Distribution of car cards and billboard posters calling attention to the opportunities offered by professional nursing will climax the nationwide student nurse recruitment program being conducted by the American Hospital Association, the Advertising Council, Inc., the American Red Cross and national nursing organizations, A.H.A. headquarters has announced. This material will be displayed throughout the country during July.

Posters, billboards and car cards feature a picture of a nurse with text emphasizing advantages and opportunities offered by nursing education. "Nursing Is a Proud Profession" is the slogan appearing on the posters, which will be distributed through facilities of the Advertising Council, representing national advertisers. The text will instruct young women interested in nursing to communicate with local hospitals for further information.

In addition, national network time will be devoted to messages on nursing urging young women to seek further information at their local hospitals and schools of nursing. National programs will carry these messages during the week of July 28. This additional week brings the total national network time allocated to the student nurse recruitment program to seven weeks.

Local recruitment programs are being coordinated with the national advertising and radio programs, according to Mildred Riese, Detroit, chairman of the American Hospital Association recruitment committee. News letters containing suggestions for newspaper stories, radio announcements and programs to be conducted in high schools, schools of nursing and at meetings of civic, social and business groups have been sent to nursing schools, hospitals and local student nurse recruitment officials to assist in the local programs.

combine **nourishment** and wide **taste appeal**
... make milk desserts a daily habit
with **Jullicum**
THE NATURALLY-FLAVORED, LIQUID RENNET

The Dietetic Virtues of rennet-milk desserts, though well known, are only occasionally recognized in practice because ordinary preparations may not have the true flavor appeal so abundant in Jullicum. As a result, less nourishing but more attractive desserts are often used, providing little more than water and a few calories from refined sugar.

But With Jullicum, the naturally flavored, liquid rennet, you can easily prepare a delightful variety of altogether different rennet-milk desserts, offering milk's matchless combination of protein, carbohydrate and fat, with minerals and vitamins as well. Jullicum liquid rennet provides eight of the finest and most appetizing natural flavors, enough for each day of the week, with one flavor extra to keep monotony out of step.

Preparation is Simple. for Jullicum is as easy to use as it is to pour, blending promptly and uniformly with milk to create attractive, quick-setting desserts with characteristically smooth, firm texture.

And the Cost is Low—only about one cent for the Jullicum Liquid rennet in each four-ounce serving. A pint will flavor and rennetize 128 such desserts and is priced at $1.50 postpaid; the price is $8 per case of six pints ($9 west of the Mississippi), express prepaid.

When You Choose a Dessert, consider the advantages of Jullicum, the naturally flavored, liquid rennet: Ready for instant use, quick blending, varied, delicious, nourishing . . . *and* economical!

SAM'L B. KIRK, 261 South Third St., Philadelphia 6, Pa.
Makers of Rennet Enzyme Preparations Since 1857
Ask for a Sample, or send your order on this coupon:

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GENTLEMEN:
☐ Please send me, without charge..... Jullicum samples, flavors as indicated.
☐ Please ship at once.....pints of Jullicum at $1.50 per pint postpaid, or $8 per case of 6 ($9 west of the Mississippi) express prepaid. Flavors indicated.

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SAMPLES	FLAVORS	PINTS
____	Vanilla	____
____	Chocolate	____
____	Lemon	____
____	Orange	____
____	Raspberry	____
____	Almond	____
____	Coffee	____
____	Buttered Caramel	____

Personnel Cuts Hit V.A. Department of Medicine and Surgery

WASHINGTON, D. C.—To meet a personnel ceiling set by the Bureau of the Budget for the fiscal year beginning June 30, the Veterans Administration's Department of Medicine and Surgery will probably be forced to lay off around 3500 employes. The cut comes at a time when, according to V.A. officials, the agency could use 13,000 additional employes in its hospitals and medical centers.

The dismissals will hit clerical workers chiefly and certain construction employes. V.A. hopes to keep personnel directly concerned with medical care. Because of the shortage of doctors, approximately 5000 beds in veterans' hospitals have already been closed this year. Another 6000, to be available in a few months, will have to remain closed unless more doctors can be engaged.

Food Prospects Good

WASHINGTON, D. C.—A wide variety of foods will be plentiful during the early summer, according to the U. S. Department of Agriculture. The abundant fruits and juices will include fresh lemons and oranges, canned grapefruit segments, canned citrus juices and canned tomato juice. At least three canned vegetables will be available in quantity: canned peas (standard grade), canned diced carrots and canned diced beets. Potatoes, both "new" and "old," will continue plentiful.

Cottage cheese will be available and reasonable in price compared to other protein foods. Fresh and frozen fish (except shellfish) also will be plentiful because of heavy fish landings and large cold storage holdings of frozen fish. Markets will continue to offer good supplies of peanut butter.

Around The Wards With Kellogg's



PATIENT BILLY: Gee whiz! I don't even miss my appendix. And I get Kellogg's cereals for breakfast, same as at home. I *like* it here! (Note: More kids eat Kellogg's than any other cereals.)



NURSE CARTER: I've got to make every minute count. That's why Kellogg's Individuals are a nurse's best friend. Save time—and dishes. They're sanitary, too. 'Scuse me. There goes my buzzer!



DIETITIAN DENNIS: Kellogg's cereals with milk provide excellent nutrition—and they're so easy to digest. Patients love the appetizing assortment. Confidentially, so does *this* lady.



GRAND NUTRITION: All Kellogg's cereals either are made from whole grain, or are restored with whole-grain nutrients declared essential to human nutrition, in accordance with the U. S. Nutrition Program.

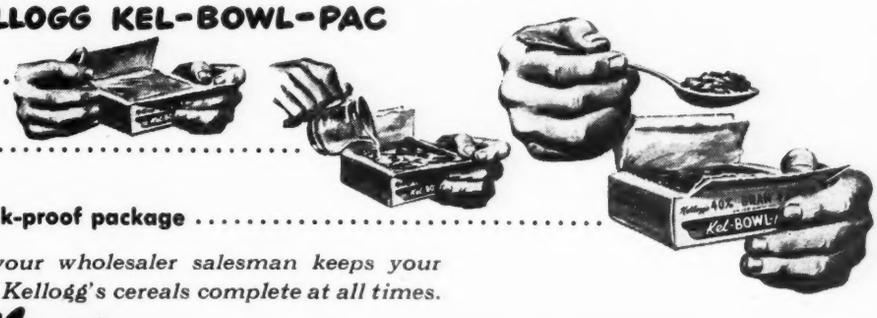
Here's Another Great Time and Dish Saver

THE EXCLUSIVE KELLOGG KEL-BOWL-PAC

1. Open the package . . . .

2. Add cream and fruit . . . . . .

3. Eat right out of the leak-proof package . . . . . .



Be sure your wholesaler salesman keeps your variety of Kellogg's cereals complete at all times.

Made by Kellogg's —THE GREATEST NAME IN CEREALS

Battle Creek and Omaha

Offers $500 Award to Psychiatric Aide Judged Outstanding

PHILADELPHIA.—An award of $500 to the psychiatric aide or attendant judged outstanding in skill and devotion was announced last month by the National Mental Health Foundation. The winning attendant will be named "psychiatric aide of the year" and presented with an appropriate citation in addition to the cash award. Additional awards of $50 and citations will be given to five nominees judged deserving of honorable mention, the foundation said.

The following qualifications will be considered by the judges in making the award: Skill, initiative and imagination in the discharge of duties; and kindness and devotion to patients.

Purpose of the awards is to focus attention on the important rôle played by attendants in the care of the mentally ill, to gain prestige for those engaged in this work and to encourage higher standards of care. Candidates for the award must be men or women now employed as psychiatric aides or attendants directly concerned with ward care of mentally ill patients. Those employed in administrative capacity are not eligible nor are graduate nurses, student nurses, occupational therapists or other professional workers.

Nominations for the awards are to be forwarded to the foundation by hospital administrators, who will accompany their nominations by statements setting forth the reasons which qualify the candidate for consideration.

Judges who will make the final selection are: Albert Deutsch, writer; Dr. Robert H. Felix, chief of the mental hygiene division of the United States Public Health Service; Mrs. Ruth P. Kuehn, dean of the school of nursing, University of Pittsburgh; June Joslyn, executive secretary of the Oregon Mental Hygiene Society; Dr. Robert L. Sutherland, director, Hogg Foundation for Mental Hygiene, University of Texas, and Mary Jane Ward, author of the "Snake Pit."

Further information about the award may be obtained from National Mental Health Foundation, 1520 Race Street, Philadelphia 2.

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FIRST AGAIN WITH MONEL
Ovens



The No. 959, one of 22 Blodgett models now also available in Monel

Now you can buy Blodgett's De Luxe No. 900 Series ovens in #35 MONEL, including complete exterior and all interior surfaces normally subject to corrosion (except shelves). This gleaming, polished metal adds to Blodgett's other famous features: Longer life Greater beauty Amazing cleaning ease Freedom from service worries. Write today for descriptive folder.

THE G. S. BLODGETT CO., Inc.
50 LAKESIDE AVE. BURLINGTON, VERMONT

Urges Revolutionary Change in Army Medical Corps Organization

WASHINGTON, D. C.—"It is high time we depart from the 16th century concept of medical organization and training," Maj. Gen. Paul R. Hawley, V.A.'s medical director, urged June 3 at a banquet held for doctors attending the Army Medical Corps' three day symposium.

Dr. Hawley proposed a medical organization to care for the army's sick and wounded during peacetime and a smaller, select medical corps to be trained specifically for war. For the army's peacetime medical job, he urged a military corps of the same type and with the same training objectives as the one to be created in the proposed armed forces reorganization bill, or a civilian agency modeled after the department of medicine and surgery of the Veterans Administration, with both full time and part time medical men.

For the smaller group of medical officers whose basic training would be readiness for war, Dr. Hawley recommended a fifteen year training program. Such a program should include, he said, formal training in hospital administration, in public health, in medical supply, in medical planning and in staff and command relationships.

The sole mission of the peacetime Army Medical Corps, Dr. Hawley observed, would be the practice of clinical medicine and its principal objective that of developing the finest clinicians in the country. He objected to the present method of giving the medical corps one primary mission in peace and a totally different mission in war.

Bargain in 3 departments



Big, Juicy, Tender, Meaty

Cloverbloom Table Dressed

Young Tom Turkeys

These large, young tom turkeys give you more generous slices of meat per pound. And, because they're Cloverbloom *Table Dressed* they offer you an extra bargain in three departments:



1. BARGAIN IN PATIENT SATISFACTION! They're the pick of the flock – young, fine, soft meated, fully fleshed. Killed and dressed at their flavor peak and quick frozen immediately. You can't serve a better-tasting turkey!

2. BARGAIN IN BETTER KITCHEN MORALE! You save time and labor with *Table Dressed* turkeys because they are immaculately cleaned and picked, tied for roasting. No wonder chefs prefer Cloverbloom *Table Dressed* turkeys!

3. BARGAIN IN EASIER ACCOUNTING! There's no guesswork on cost. The waste is gone. The preparation time is eliminated. Use Cloverbloom *Table Dressed* turkey just once and from then on you can figure portion costs accurately and easily. Order from Armour now!

Quick Frozen Flavor Fresh

Armour Creameries • Chicago 9, Illinois

Murray Bill Proposes New National Health and Insurance Program

WASHINGTON, D. C.—A national health insurance and public health program bill was introduced by Senators Murray, Wagner, Pepper, Chavez, Taylor and McGrath on May 20.

The President in a message preceding introduction of the bill urged: more hospitals and more doctors where they are needed; adequate public health services, including an expanded maternal and child health program; additional medical research and medical education; insurance against the costs of medical care, and protection against loss of earnings during illness.

The current bill, S.1320, makes five provisions for the health of our population:

1. A comprehensive national system of prepaid personal health services, with decentralized administration to be carried out by the states and local agencies.
2. Authorization to use federal grants-in-aid to the states (public assistance) toward paying for personal health services furnished to needy persons.
3. Improved federal grants-in-aid to the states for comprehensive, community-wide, public health and maternal and child health services.
4. Improved federal grants for the construction of needed hospitals and other health facilities.
5. Grants-in-aid, under the prepaid medical care plan, to aid nonprofit institutions that engage in research or in professional education.

Nellie Gorgas Cited for Distinguished Service

MINNEAPOLIS.—Nellie Gorgas, director of St. Barnabas Hospital, was one of nine graduates of the University of Chicago who was presented with a citation as an outstanding graduate for distinguished service in the community at the university's recent commencement. Citations were given to members of the classes from 1922 back to the beginning of the university.

Following is the complete text of the citation she received:

"The Alumni Association of the University of Chicago holds that a university education should be the training and inspiration for future unselfish and effective service to the community, the nation and humanity; and

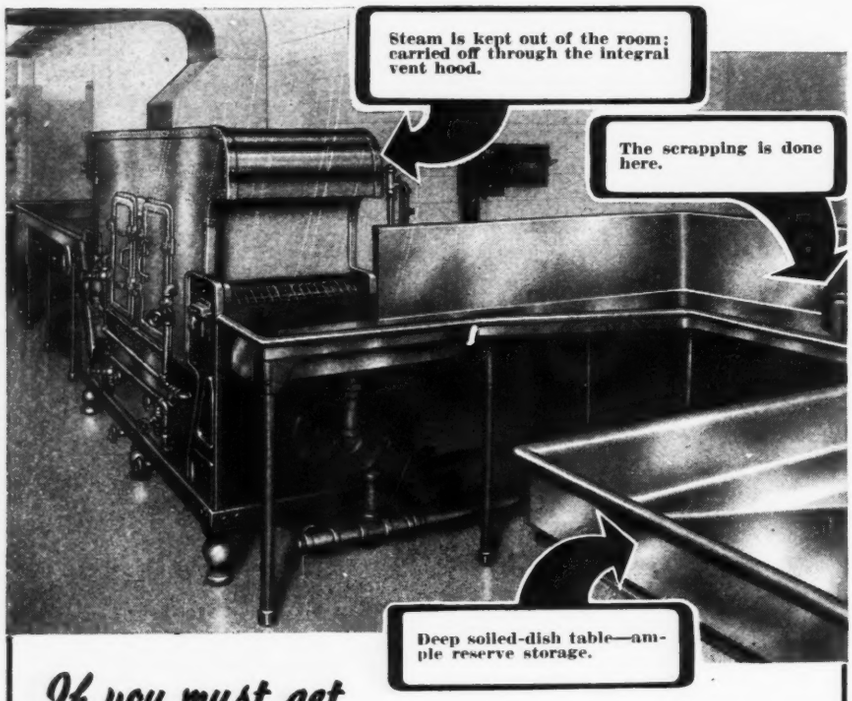
"That men and women in accepting the privileges of a university education assume also the obligation to society to exercise leadership in those civic, social and religious activities that are essential to a democracy.

"Nellie Gorgas, an alumnus of the University of Chicago, having, in the judgment of the Alumni Association, demonstrated a practical acceptance of these obligations and responsibilities by public-spirited citizenship, is hereby declared a worthy alumnus and awarded the Alumni Citation of Useful Citizen.

"In making this citation the Alumni Association acknowledges with pride the service which has reflected credit on the University and its alumni."

Plans Expansion Program

The George F. Geisinger Memorial Hospital, Danville, Pa., is planning an expansion program which will cost a minimum of $1,000,000, it was announced last month by F. J. Platt, chairman of the Geisinger advisory board. Plans include construction of a five story diagnostic clinic, revamping of the main building to provide 47 additional beds, boosting the inpatient capacity to 300. enlarging the nurses' home to create housing and recreation facilities for a greater number of both graduate and student nurses and enlarging of the laundry to provide more space and equipment needed to handle the increased volume of work that is being done there.



If you must get

BIG Capacity

in a small, awkward space—



—study this picture. The 600-G Belt Conveyor Champion washes all tableware for up to 1,250 diners per meal—in an L-shaped installation covering only 90 sq. ft.

If you're interested in *lowest possible labor cost* see the records of Champion Belt Conveyor machines, in which the dishes are placed directly on a moving belt. Dependability is practically 100%, as Champions of this type have been built for many years, and perfected by constant improvement.

The Champion line also includes automatic rack type machines with the simple Hydro-Drive feed . . . and for smaller requirements, splendidly built hand feed machines. Write for catalog.

CHAMPION DISH WASHING MACHINE CO., Erie, Pa.

For MOST SATISFACTION *and* LEAST TROUBLE

CHAMPION

Dish Washing Machines

DOES THE SERVING SPOON *Serve You?*



Heavy-handed kitchen help often allow the serving spoon to regulate portion measurement—with overportioning as the result. This waste can be eliminated with Lily* Portion Cups. They assure effective control of the number of ounces per portion—and the number of servings you can obtain from identical purchases.

The nine sizes of Lily Portion Cups—from ½ to 5½ ounces—provide crisp, clean paper service for every need. Attractive and sanitary, sturdily made, they are designed for accurately portioning vegetables, fruits and desserts, salads, puddings, condiments and sugar, mayonnaise, jams and jellies.

By allowing preportioning, Lily Cups eliminate much of the mealtime rush for hurried kitchen staff and nurses. They are light and easy to handle. There is no breakage, no collection problem, no dishwashing chores—used cups are simply discarded.

Lily Portion Cups efficiently fill many needs in dispensaries and pharmacies too . . . as tumbler covers, as pill, lozenge and capsule containers, as receptacles. Full information will be sent upon request. Just mail the coupon below. LILY-TULIP CUP CORPORATION . New York . Chicago . Kansas City . Los Angeles.

Lily Cups

*Trade Mark Reg. U. S. Pat. Off.

LILY-TULIP CUP CORPORATION
122 East 42nd Street, New York 17, N. Y.

Please send me your free kit containing samples of your Lily Portion Cups.

Name of Hospital.....

Street Address.....

City and State.....

Your Name.....



IT'S A WISE OLD OWL

WHO KEEPS AN EYE ON WASHROOM EXPENSE

• STRAUBEL towels and tissues give you better value and service at lower upkeep costs!





A TRIPLE SERVICE!

DISTRIBUTED THROUGH PAPER MERCHANTS ONLY

Write for name of merchant best located to serve you.

Straubel
TOWELS & TISSUE

STRAUBEL PAPER CO. • GREEN BAY • WIS.

Senate Passes National Science Foundation Bill

WASHINGTON, D. C.—The Senate on May 20 passed the bill, S.526, to establish a National Science Foundation. A similar bill passed last year by the upper law-making body died in a House committee. The legislation just passed authorizes the expenditure of $20,000,000 a year to advance research in mathematical, physical, medical, biological, engineering and other sciences, and to initiate research in connection with the national defense.

Not less than 25 per cent of the funds would be apportioned among the states to carry on research activities in the facilities of tax supported colleges and universities, including the land-grant colleges. Other funds would go for scholarships and graduate fellowships awarded by the foundation to promising young scientists.

The director of the foundation to be appointed by the President would receive $15,000 yearly. A board of 24 members would be appointed from the top ranks of scientists, engineers, educators and men of public affairs.

Group Hospitalization Reports Record Expansion

WASHINGTON, D. C.—Group Hospitalization, Incorporated, in May reported a net gain of 60,000 subscribers in 1946. Its membership has now reached a new high of 305,000. Although the agency has granted a substantial increase in its payments to hospitals serving G.H.I. subscribers, the president, Joseph H. Himes, expressed his hope and belief that subscriber rates would not be increased during the current year.

An announcement will shortly be made, according to Mr. Himes, on a combined medical care and hospitalization program. The new program has been developed through the cooperation of Group Hospitalization and the District Medical Society.

Rate Increase for Chicago Blue Cross Members

CHICAGO.—Plan for Hospital Care, Chicago Blue Cross, has sent an announcement to enrolled groups explaining an increase in subscriber rates. The increase was made necessary by mounting hospital costs, a letter from E. P. Lichty, executive director, explained. Average cost of a day's hospital care in Chicago rose from $7.05 in 1942 to $9.51 in 1946 and $12.15 in April 1947, Mr. Lichty declared. The letter was accompanied by a poster explaining the necessity for increasing rates.



IF YOU

had to Clean the Hospital ware

YOU would insist on ALCONOX

No matter what you want to clean . . . blood encrusted pipettes, metal ware, porcelain ware, machine parts . . . No matter how dirty or greasy they be . . . ALCONOX will make them sparkle, film-free, streakless.

In Hard Water, Soft Water

Hot or cold, Alconox is equally effective. It actually lifts off dirt, grime and grease faster than anything you have ever tried.

Saves Energy, Saves Time

Just wash and rinse. Practically no need of toweling. Economical, too—One spoonful makes a gallon of active cleanser ready to go to work on your toughest job.

Tested and Used

by many leading hospitals, laboratories, food and industrial plants.

Test it yourself . . . *on a tough job.*

You'll agree with these users.

•

"You will be pleased to learn that we have tried Alconox in washing all our walls and especially on the very fancy decorative designs in the new solariums in the hospital, and we believe it to be the last word in wall cleaning."
Hospital Supt.

"Blood-clogged pipettes were cleaned readily by immersing in the solution."
M.D.

•

"Please send me a carton of Alconox. It is the best powder that I have ever used for Laboratory glassware."
Hospital Supt.

3-lb. box $1.25; 12-box carton $13.50
50-lb. bags @ 32c lb. f.o.b. New York

Order today or write for free sample.

STANDARD SCIENTIFIC SUPPLY CORP.
34-38 W. 4th St., New York 12, N. Y.

ALCONOX *cleans better cleans quicker*

If you use as little as 500 pounds of ice a day...

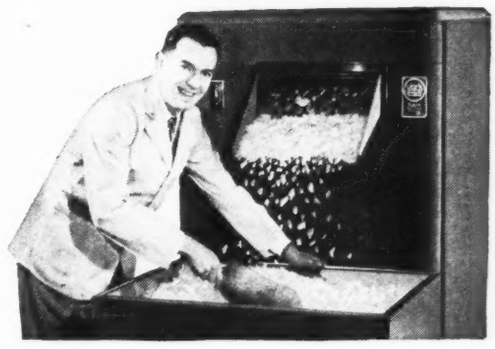
You can Save 25 to 60 percent

Saving money is *making* money. The day you start making your own FlakIce Frosty Ribbons, *at the flick of a switch*, you start increasing profits. The experience of other hospitals has been a reduction of ice costs as much as 25 to 60 percent.

And here is ice in its most useful form . . . for ice bags, for ice therapy, for chilling beverages and preserving delicate foods . . . ice that is untouched by human hands and hence as pure as the water you pipe into the machine.

This amazing ice maker is self-contained in a handsomely finished, durable steel cabinet that requires but 2 x 3 feet of floor space. Flip the switch, and it starts producing ice in 60 seconds, will make up to 1 ton per day. Your FlakIce Machine requires only water and electric connections. And, best of all, it's available *now*. Immediate orders mean immediate delivery . . . so, mail the coupon today, *now!*

York Corporation, York, Penna.



FILL IN NOW...MAIL AT ONCE!

YORK CORPORATION
YORK, PENNA.

Gentlemen:—

I am interested in FlakIce Frosty Ribbons. We now use about_____lbs. of ice per day at a cost of \$_____per hundred. How much can we save?

*Name*_____

*Street & No.*_____

*City*_____ *State*_____

MH-7

YORK *Refrigeration and Air Conditioning*

York refrigeration air conditioning

HEADQUARTERS FOR MECHANICAL COOLING SINCE 1885

Recommend Action on D. C. Nursing Situation

WASHINGTON, D. C. — Recommendations concerning the local nursing situation, made after careful study by the executive committee of the National Capital Area Hospital Council, have been approved by the council, according to J. G. Capossela, chairman of the committee and superintendent of Emergency Hospital in an interview June 18. The study was initiated by the council because of the acute nurse shortage here and because of prolonged controversy over legislation to set up licensing requirements for the city's practical nurses.

The following recommendations were made by the committee:

1. That further study and consideration be given to the bill for the licensing of practical nurses but no action be taken before next January.

2. That an in-training program for nurse's aides, which would meet the requirements for training of practical nurses, be set up in all hospitals.

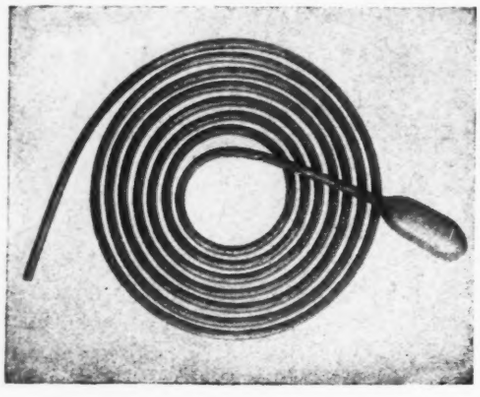
3. That at least two of the five members of the present nurses' examining board be directors of nursing in hospitals having nursing schools.

4. That practical nurses be licensed by a board including two representatives each of the Graduate Nurses' Association and the Undergraduate and Practical Nurses' Association, and one each of the hospital council, board of education, medical profession, public health officials and professional women's organizations.

5. That an advisory council be appointed to the nurses' examining board, made up of the president of the Graduate Nurses' Association and two members each of the hospital council, the District Medical Society and local educational leaders.

A *simplified* tube for
INTESTINAL INTUBATION

Described by Dr. Meyer O. Cantor, Detroit, American Journal of Surgery, July 1946 and April 1947.



The CANTOR TUBE

The CANTOR TUBE is a latex bag-tipped, mercury weighted, single lumen tube. It is 18 Fr. and 10 feet long. Its movement down the alimentary tract is actuated by a combination of free-flowing qualities of the mercury and the peristaltic action on the bolus formed by the mercury in the bag. Mercury is given the maximum motility by the loose latex bag attached distal to the tube. It is the only tube utilizing all the physical properties of mercury.

Tubes are marked as follows to indicate their position: "S" for stomach at the 17" mark, "P" for pylorus at the 24" mark, "D" for duodenum at the 30" mark, then in feet at the 4, 5, 6, 7, 8 and 9 feet marks.

Secondary dilatation of the stomach can be decompressed by withdrawing the tube a short distance, cutting holes into the tube, and allowing the tube to be pulled down by peristalsis at which point the holes will open to the stomach which, on applying suction, will be decompressed.

Replacement latex bags are easily cemented to the tube.

FEATURES . . .

1. ***Greater ease of intubation*—first, ease of passage through the nares and nasopharynx; and second, *ease of passage through the pylorus.* Of 100 cases 96% were *successfully intubated.***
2. ***More efficient decompression*—resulting from larger luminal diameter and *less possibility of plugging.***
3. **Complete absence of any metal parts which might injure the mucosa.**

D-110 CANTOR INTESTINAL DECOMPRESSION TUBE, 18 Fr., 10 feet long, with bag attached, with instructions for use. Each $7.50

D-110/B LATEX BAG for Cantor Intestinal Decompression Tube, with instructions for replacement of bag. (With each dozen bags one tube of D-110/C Cement is supplied without charge). Each $.60, Dozen $6.00

D-110/C RUBBER CEMENT for attaching replacement bags to the Cantor Tube. Each $.25, Dozen $2.50

Order from your Surgical Supply Dealer

CLAY-ADAMS CO INC.
44 EAST 23rd STREET, NEW YORK 10, N. Y.

St. Louis Foundation Studies Health Needs

Initial studies conducted by the Doctors' Medical Foundation in St. Louis revealed that the health needs of the city and the area within a 50 mile radius could be supplemented to provide maximum service, although greater St. Louis has 174 doctors for every 100,000 population and approximately six general hospital beds per thousand population—both ratios well above the national average.

The foundation, comprised of a group of St. Louis physicians and surgeons, has filed with the Circuit Court of St. Louis County for a Pro Forma Decree under which it will continue nonprofit studies in hospital care and medical administration and will initiate research in medicine. The ultimate goal of the foundation is, on the basis of exhaustive surveys, to construct and operate a hospital in accordance with the recommendations resulting from its findings and from national studies.

Officers of the foundation are: president, Dr. Grey Jones; vice president, Dr. Louis H. Jorstad; secretary, Dr. Raymond O. Muether; treasurer, Ray F. McCarthy.

Appropriation Approved for D. C. Center

WASHINGTON, D. C.—An appropriation of $1,700,000 was approved by the House appropriations committee June 13 for the proposed 1500 bed hospital center here. The amount is more than a million less than the $2,750,000 originally asked for the site and the plans. The navy, however, has signified its willingness to transfer part of the Naval Observatory tract for the hospital site.

Before approving the appropriation, the committee held closed hearings in which testimony disclosed the need for additional hospital facilities for the District. Alan Johnstone of Federal Works Agency testified that Washington needs 2750 new hospital beds. The president of Garfield Hospital declared that poorly equipped hospitals do not attract the right kind of interns.



Number 6 in a series

Frank Howard Swett

A life of service until a cat scratched him!

NEW ENGLANDERS who were experimenting with the still young Roentgen Ray were always mighty glad to see Frank Swett.

For this generous, cheerful man, who distributed x-ray equipment, had great technical knowledge. He helped solve many a crisis in laboratories and hospitals.

In business with his brother, Frank Swett constantly demonstrated and tested the equipment he was distributing, without a thought for his safety.

As a result, dermatitis appeared very early on the back of his left hand—followed by keratoses. These persisted on and off for the rest of his life. It is noted that more radium was used in treating Swett than in any other case of dermatitis among the pioneers.

But this malady never drained Swett's great energy; until, early one summer, a cat accidentally scratched a recent skin graft. Infection spread. Amputations and operations failed to save Frank Swett's life. He died in 1929, having suffered most of his years.*

• • •

It has taken the perseverance and sacrifice of many men in many professions to tame the miracle of x-ray.

You can be sure that we at Ansco shall do all in our power to see that x-ray continues to serve man—ever better—ever more exactly. We shall continue to manufacture x-ray films and chemicals of unfailingly high quality. Ask for Ansco materials. You can depend on them for radiographs of maximum diagnostic quality. **Ansco, Binghamton, New York.**

*American Martyrs To Science Through The Roentgen Rays, by Percy Brown, M.D. Published by Charles C. Thomas, Springfield, Illinois.

ASK FOR

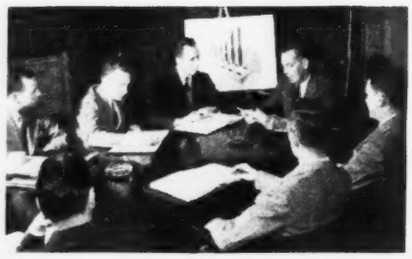
Ansco

X-RAY FILMS AND CHEMICALS

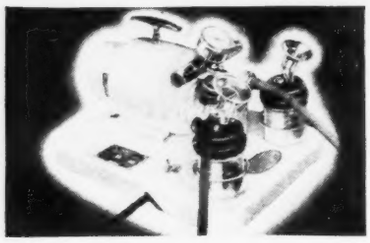
Assign Administrative Interns

ST. LOUIS.—Assignments of administrative internships to students in hospital administration at Washington University, St. Louis, have been announced as follows, according to Graham F. Stephens, associate director of the university's department of hospital administration:

Ted Bowen, Barnes Hospital, St. Louis; Victor E. Costanzo, Grace-New Haven Hospital, New Haven, Conn.; Harold L. Hutchins, Grasslands Hospital, Valhalla, N. Y.; Howard Lehwald, St. Luke's Hospital, St. Louis; Charles McLean, Barnes Hospital, St. Louis; Frank J. Moore, Huron Road Hospital, East Cleveland, Ohio; David C. Reynolds, Madison General Hospital, Madison, Wis.



Washington University interns, clockwise from upper left: Ted Bowen; Harold L. Hutchins, Charles McLean, Dr. Frank R. Bradley, director of the course, David C. Reynolds, Frank Moore and Howard Lehwald.



This **GOMCO ROTARY BREAST PUMP**

provides

FREEDOM FROM CONTAMINATION
PATIENT COMFORT • ALL-AROUND CONVENIENCE
QUIET OPERATION • TROUBLE-FREE PERFORMANCE
SPACE SAVING • ATTRACTIVE APPEARANCE

Using a sturdy rotary pump (rather than cylinder piston type) this Gomco Breast Pump gives CONTINUOUS suction . . . keeping any contaminated air columns from being recirculated.

The Gomco Rotary Breast Pump is particularly safe for the patient, too, because she can easily control the degree of suction.

The unit as a whole is quiet running, light and compact. No visible moving parts, no valves or pistons to wear out. Glass trap, removable for cleaning, prevents damage to pump from overflow. Glass nipple shields and rubber covers fit the two 4 oz. bottles, on which feeding nipples can be attached. A truly convenient and long-lasting breast pump, appreciated by patient and physician alike.

GOMCO SURGICAL MANUFACTURING CORP.
824H E. Ferry St., Buffalo 11, N. Y.

GOMCO EQUIPMENT
Fostering Improved Technics

Paralysis Foundation Sets Up Committee on Hospital Care

The increasing tendency of general hospitals to accept poliomyelitis patients has resulted in the appointment of a special hospital care committee of the National Foundation for Infantile Paralysis, Basil O'Connor, foundation president, announced last month.

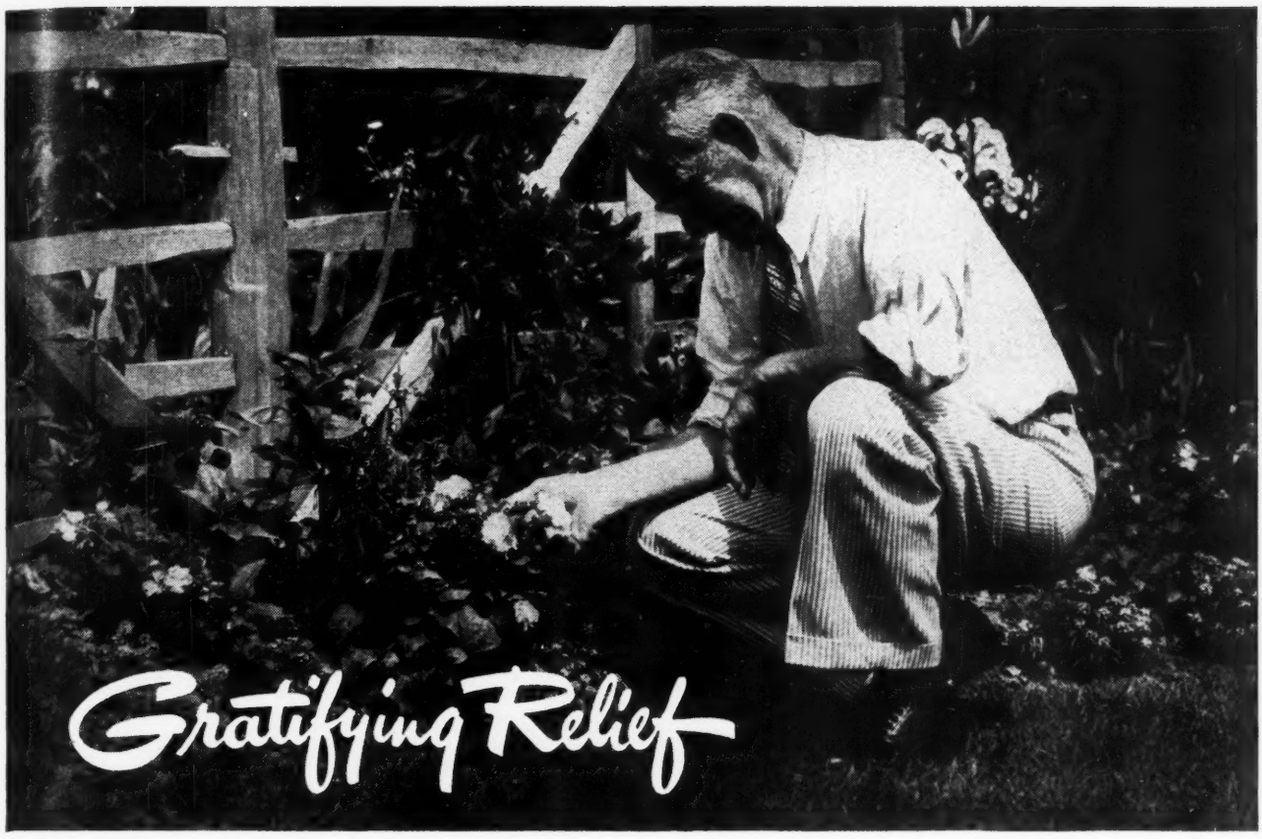
Members of the hospital committee, which held its first meeting in New York City last month, are: Dr. Arthur C. Bachmeyer, University of Chicago Clinics, Chicago; Msgr. John J. Bingham, director of Catholic Charities, New York City; Dr. Robert H. Bishop Jr., University Hospitals, Cleveland; Dr. Robin C. Buerki, University of Pennsylvania Hospital, Philadelphia; George Bugbee, American Hospital Association, Chicago; Dean Conley, American College of Hospital Administrators, Chicago; Albert W. Dent, Flint-Goodridge Hospital, New Orleans; Dr. Edwin L. Harmon, Grasslands Hospital, Valhalla, N. Y.; Dr. Basil C. MacLean, Strong Memorial Hospital, Rochester, N. Y.; Dr. Claude W. Munger, St. Luke's Hospital, New York; Charles G. Roswell, United Hospital Fund, New York; Dr. Donald C. Smelzer, Germantown Dispensary and Hospital, Philadelphia; Dr. A. L. Van Horn, chief, Crippled Children's Division, Children's Bureau, Washington, D. C.; Frank J. Walter, Good Samaritan Hospital, Portland, Ore.

Dr. Bachmeyer was named chairman of the committee and Catherine M. Maloy has been appointed director of hospital services for the foundation. Miss Maloy was formerly on the staffs of the University of Pennsylvania Hospital and the University of Chicago Clinics.

Cincinnati Plan Opens Advertising Campaign

An experimental advertising campaign announcing an open membership period during which all employes of enrolled groups may apply for membership was started in May by Hospital Care Corporation, Cincinnati Blue Cross, and will be continued to July 10.

"Blue Cross is conducting this experimental advertising campaign in order to test the effectiveness of advertising in educating members and enrolling new members," an announcement by Hospital Care Corporation at the beginning of the open membership period said. "Actually, advertising furnishes the least expensive means of reaching our present membership. For example, this campaign will cost approximately the same amount as a single letter mailed to 40,000 of our subscribers—which will reach less than one sixth of our total membership."



for the patient with distressing urinary symptoms

The prompt symptomatic relief provided by Pyridium is extremely gratifying to the patient suffering from distressing symptoms such as painful, urgent, and frequent urination, nocturia, and tenesmus.

Pyridium, administered orally in a dosage of 2 tablets *t.i.d.*, will promptly relieve these symptoms in a large percentage of ambulant patients, thereby permitting them to pursue normal activities without undue discomfort.

Since Pyridium acts directly on the mucosa of the urogenital tract, this important effect is entirely local. It is not associated with or due to systemic sedation or narcotic action.

Therapeutic doses of Pyridium may be administered with little fear of serious toxic effects throughout the course of most cases of cystitis, pyelonephritis, prostatitis, and urethritis.

Literature on request.

REG. U. S. **PYRIDIUM** PAT. OFF.

(Phenylazo-alpha-alpha-diamino-pyridine mono-hydrochloride)

MERCK & CO., Inc. RAHWAY, N. J.

Manufacturing Chemists

In Canada: **MERCK & CO., Ltd. Montreal, Que.**

PYRIDIUM is the United States Registered Trade-Mark of the product manufactured by the Pyridium Corporation Merck & Co., Inc., Sole Distributors in U. S. A.

Col. Blanchfield Retires as Army Nurse Corps Head

WASHINGTON, D. C.—Col. Florence A. Blanchfield completed her tour of service as superintendent of the army nurse corps on May 31, retiring with twenty-nine years of service to her credit. Col. Blanchfield entered the army nurse corps in July 1917, serving overseas during World War I with Base Hospital No. 27 and other units of the medical corps.

Since the first World War, she has had assignments in the Philippines and China. In 1935 she was assigned to the Office of the Surgeon General. In 1942 she was promoted to lieutenant colonel and assigned as first assistant of the army nurse corps. The next step up was her appointment by the Secretary of War as superintendent of the corps; this appointment was made in 1943.

As superintendent she was responsible for establishing and maintaining efficient nursing care for the thousands of American sick and wounded soldiers all over the world. To Col. Blanchfield goes much of the credit for obtaining full military rank for nurses through Public Law 36, 80th Congress, signed by the President April 16.

Addition to Mercy Hospital

HAMILTON, OHIO.—Construction was undertaken last month on an addition to the Mercy Hospital at Hamilton, Ohio.



Right Reverend Msgr. R. Marcellus Wagner, director of the Catholic hospitals for the archdiocese of Cincinnati, gave the principal address at the cornerstone ceremonies.

New York Hospital Marks 176th Year

The 176th birthday of the New York Hospital, oldest in New York City and one of the oldest in the country, was observed in May with a ceremony at which it was announced that the hospital is to have a new diagnostic clinic. The clinic will be constructed with a gift which has already been made to the hospital, according to William H. Jackson, hospital president.

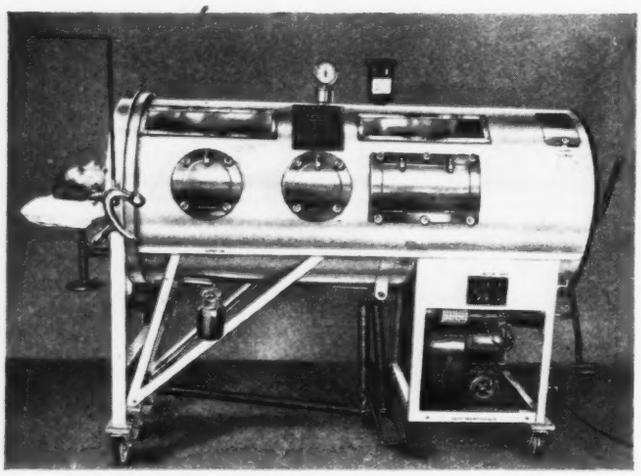
The New York Hospital was chartered in 1771 by King George III of England. Its first patients were American soldiers wounded in 1776 in a Revolutinary War skirmish. The hospital is affiliated with Cornell University medical school.

Revise Standards for Adhesive

Hospitals as well as manufacturers and distributors of adhesive materials have been invited by the Division of Simplified Practice of the National Bureau of Standards to make suggestions in connection with the committee's proposed revised standard for adhesive plasters. The committee has issued a proposed simplified practice recommendation R85-43 covering various types and sizes of adhesive plaster now in common use and is looking toward final decision as soon as the proposed revision has been reviewed by the users and industry.

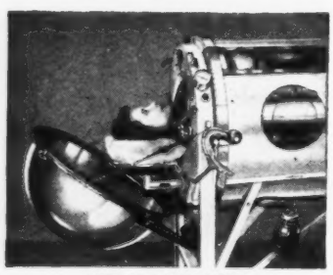
Seeks $250,000

MOUNT KISCO, N. Y.—A campaign for $250,000 to build and equip an addition to the Northern Westchester Hospital, Mount Kisco, N. Y., was announced last month by Carl Tucker, president of the hospital board.

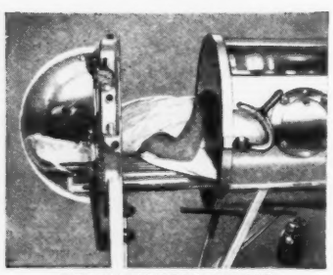


PREPARE for POLIO with The *New*

EMERSON *"Iron Lung"* RESPIRATOR



NEW EMERSON

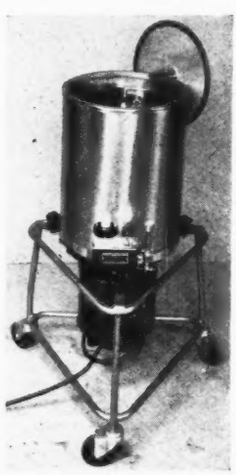


RESPIRATION DOME

Standard equipment for polio and any other long term respiratory involvement.

With the new Emerson respiration dome (*patent pending*) that breathes for the patient while the respirator is open. For the administration of hot packs and other physical therapy.

EMERSON HOT PACK



Heats, moistens and wrings out packs in two minutes. Does a quicker, neater job, and saves time of your personnel.

Write for your copy of the new Emerson Hospital Equipment Bulletin.

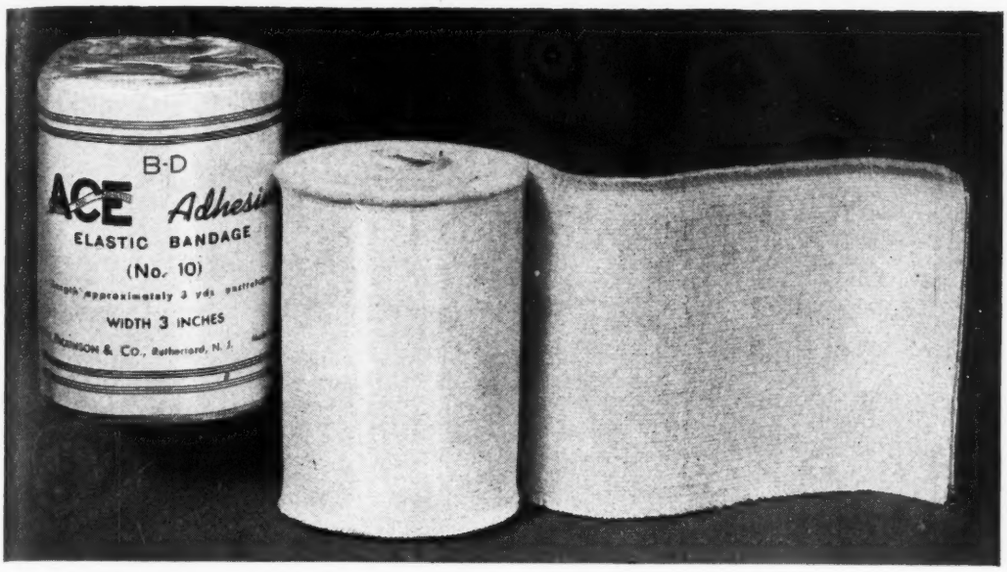
J. H. EMERSON CO.

Representatives in Principal Cities

22 Cottage Park Avenue, Cambridge, Mass.

NOW... ACE *Adhesive* (No. 10) in a

Adhesive Cotton Elastic Bandage



NEW

TESTED ECONOMY PACKAGE

ESPECIALLY DESIGNED FOR *HOSPITAL* USE

The Ace *Adhesive* Bandage (No. 10) combines the elasticity and wearability of the famous *Cotton Ace,* plus the advantage of a carefully prepared adhesive coating . . . Especially desirable for: phlebitis, impetigo, post operative bandaging and in many other fields where occlusive dressings are indicated.

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1. Smooth semi-permeable adhesive backing is water-repellent.
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Doctor's Hospital Plans Addition

WASHINGTON, D. C.—Construction of a four story $175,000 addition was announced in May by Doctor's Hospital. The expansion will provide additional bed and laboratory space for a tumor detection clinic. Four stories will be added to the hospital's north wing, now a seven story structure. The rest of the building is 10 stories in height.

The eighth and ninth floors of the addition will contain private rooms; the tenth will have a clinical laboratory. The eleventh floor will have an auditorium seating 150 and two classrooms for the training of student nurses. Each of the private rooms will be so constructed that it can be divided into two semi-private rooms.

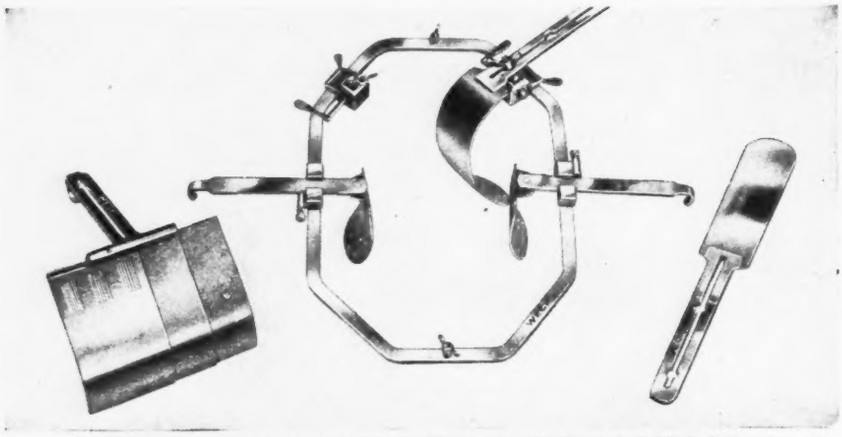
Personnel Institute Announced

HARRISBURG, PA.—An institute on personnel relations will be held for members of the Hospital Association of Pennsylvania at Pennsylvania State College, August 15 and 16, John F. Worman, executive secretary, has announced. The institute will be sponsored by the association's committee on public education.

Indiana U. Offers Intensive Courses in Nursing Education

Two intensive courses will be offered by the nursing education department at Indiana University, Bloomington, Ind., this summer. The first is a study on "Teaching of Health in Schools of Nursing." It will deal with methods of incorporating the teaching of health in the basic nursing curriculum through curriculum revision, faculty education and the utilization of public health nursing personnel and public health agencies. This course will be given July 7 to 19 under the chairmanship of Eugenia K. Spalding, professor of nursing education, Indiana University.

The second course, which will be held from July 28 to August 9, is called "Survey Methods Applied to Basic Nursing Curricula and Hospital Nursing Services." This is an intensive study of the purposes, sources of obtaining standards, research methods and the preparation of schedules in connection with surveys of schools of nursing and hospital nursing services, with emphasis on the use of the survey in program planning.



2 ENTIRELY *NEW* MECHANICAL PRINCIPLES FEATURE THIS ABDOMINAL RETRACTOR

The above illustration shows the NEW Wexler Retractor* with three of its blades in position. At the sides are shown the first of the new mechanical principles used, i.e., the 6 inch EXPANDABLE blade. With this blade on the retractor you may expand to any desired width. Also shown at the side is the flexible blade which may be bent to any desired shape or angle.

The second new principle which is an integral part of the Wexler is the use of a universal joint (two shown on the retractor above), which permits the blades to be held SECURELY in any position, at any angle, or at any depth desired — *indefinitely*.

As revolutionary as are these two new mechanical principles embodied in the Wexler, you can still use as part of it, if desired, a Deaver blade, slightly modified; or the standard blades of existing self-retaining retractors.

Now in production, available shortly — complete with hexagonal frame, 2 universal joints, 1 flexible blade, 2 curved blades, 1 expandable blade, at $140.00. Guaranteed unconditionally by Weck. Order now. Remember the Wexler eliminates need for assistants and is POSITIVE at all times.

*As illustrated and described in July 1947 issue of AMERICAN JOURNAL OF SURGERY.

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ABOUT PEOPLE

(*Continued From Page* 84.)

Wang as director of the hospital's school of nursing.

Dr. Eugene D. Rosenfeld, a graduating member of the house staff of Montefiore Hospital, New York City, has been appointed assistant director of that institution; he assumed his duties on July 1.



Frank R. Shank, who completed his administrative internship at the University of Chicago Clinics on June 30, has been appointed assistant superintendent of the clinics. Mr. Shank was a student in the graduate program for hospital administration at the University of Chicago during the academic year 1945-46 and received his master's degree.

Department Heads

Dr. John Rankin Birmingham has been made pediatrician-in-chief of the new full time department of pediatrics at Alexander Blain Hospital, Detroit.

Mrs. Hertha McCully, formerly of Shadyside Hospital, Pittsburgh, has been appointed executive housekeeper of Jewish Hospital of Philadelphia, succeed-

lest the operation be successful . . .



. . . but the convalescence a failure

Despite successful surgery, recovery is sometimes prolonged by failure to fortify the patient nutritionally against preoperative, surgical, and postoperative stress. Especially vulnerable to the ordinary demands of these states of stress are the water-soluble C and B factors intimately involved in normal cell metabolism and reparative processes.

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Nicotinic Acid Amide (Nicotinamide)	50.0 mg.
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Cebēfortis is available in bottles of 100 and 500.

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ing **Mrs. Mabel Madison** who is now housekeeper of Wilshire Hospital, Los Angeles. Mrs. McCully began her professional career in the hotel industry, later switching to hospitals. She was executive housekeeper for three years at Wesley Memorial Hospital, Chicago.

Jeanne Sobol is the new head of the dietary department, Alexander Blain Hospital, Detroit. She is a graduate of Wayne University and interned in dietetics at Massachusetts General Hospital.

Mina Hausmann has resigned as director of nurses of Evangelical Hospital of Chicago after twenty-five years of service in the institution. A reception attended by the board of directors, the medical staff and all nursing personnel was tendered to Miss Hausmann in recognition of her services to the hospital.

Mrs. Sophie Zimmermann has been appointed supervisor of the newly created personnel relations department of the University of Chicago Clinics. Mrs. Zimmermann has been special service officer, in charge of credits and collections, for the clinics since 1933.

Marjorie Goslin has been appointed director of public relations for New York Eye and Ear Infirmary, New York City. She will coordinate public relations with maintenance fund raising.

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70MM FILM FOR DETAILED STUDY

70mm stereoscopic pairs—on roll or cut film—can now be scanned with full third dimensional effect against a vibrationless and adjustable light that closely approximates daylight.

With the *new* Fairchild Stereo Viewer, the radiologist can work with a minimum of eyestrain. The 70mm film is lighted by two 25-watt incandescent bulbs placed behind a blue flashed opal diffusing screen. The intensity of the light is adjustable to compensate for over-or-under exposure of the negative or to sharpen the detail in any suspicious area of the image. The light can be used continuously without overheating. Further, the adjustable light intensity and the viewer's eye shield make it possible to scan at full efficiency in ordinary room lighting.

With the *new* Fairchild Stereo Viewer, the accurate positioning of the stereo pairs is simple and rapid—because the Fluoro-Record Camera automatically produces the proper separation between negatives.

Fairchild Stereo Viewers were designed especially for use with Fairchild Fluoro-Record Cameras—now available on leading 70mm X-ray equipment.

The same precisionized electronic and mechanical skill—that ranks Fairchild Aerial Cameras and Navigational Instruments with the world's finest—also produces: 70mm FLUORO-RECORD . . . Film Viewers . . . Cameras . . . Cut Film Adapter Back and Film Holders . . . Roll Film Developing and Drying Units. Also the Chamberlain X-ray Film Identifier. All are available through your X-ray Equipment Supplier.

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Miscellaneous

Dr. Ross T. McIntire, former surgeon general of the U. S. Navy and White House physician, has been made head of the Washington Metropolitan Health Council. He succeeds **Dr. Herbert P. Ramsey,** who has served as chairman of the council since its institution in 1944. **Howard Strong,** former head of the department of health division of the U. S. Chamber of Commerce, was named vice chairman.

Dr. A. C. Ivy, vice president of the University of Illinois, has been appointed executive director of the National Advisory Cancer Council. The post has been vacant since the resignation of **Dr. George M. Smith** of the Yale University Medical School.

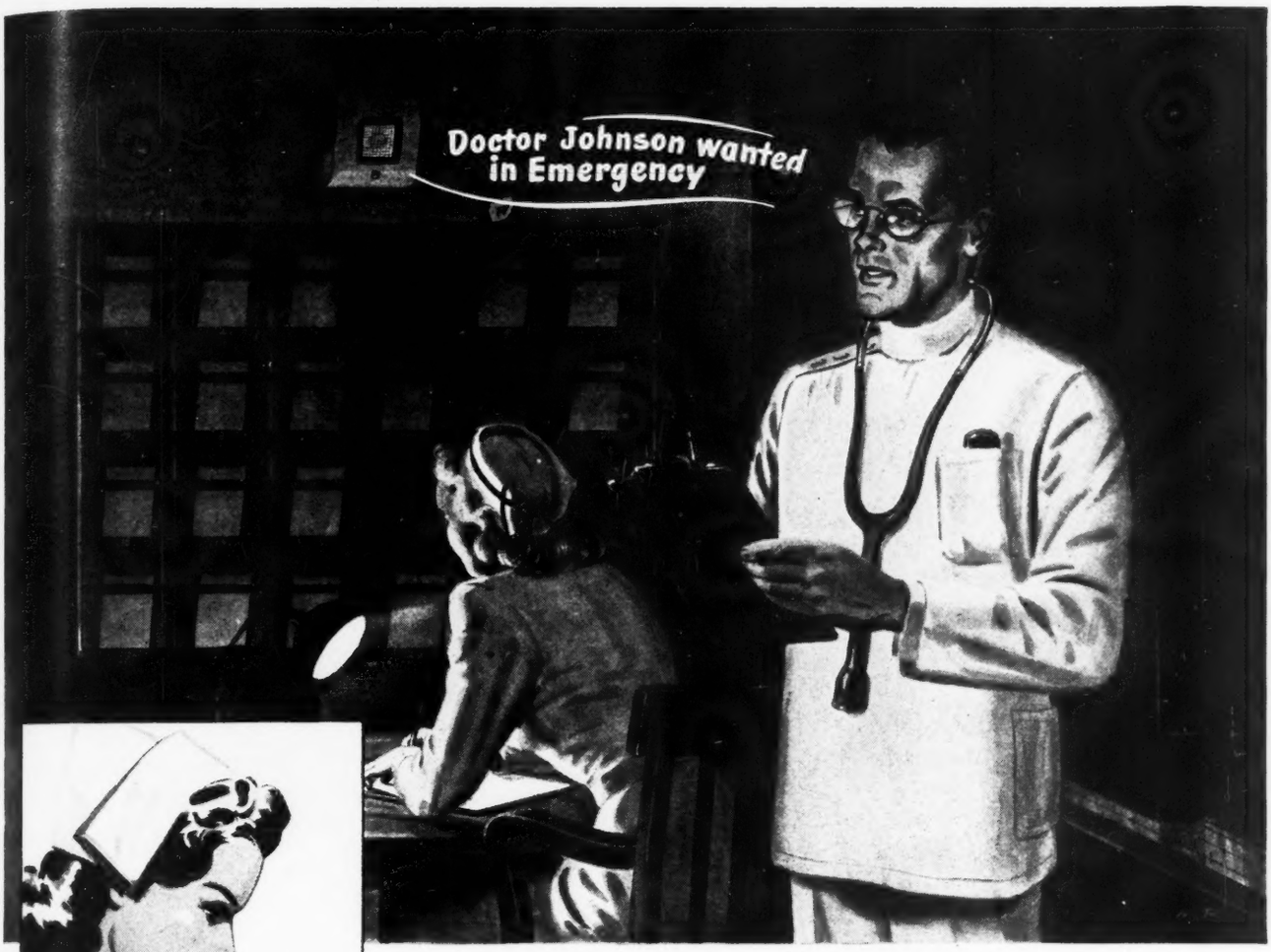


John V. Connerton has been appointed executive secretarty of the Greater New York Hospital Association. Mr. Connerton was civilian assistant to the Assistant Secretary of the Navy and a former assistant professor of history at Fordham University.

Dr. Leonard A. Scheele succeeded **Dr. R. R. Spencer** July 1 as director of the National Cancer Institute. Dr. Scheele, until now assistant chief, has been with the U. S. Public Health Service since 1933. During the war he was in charge of preventive medicine for the allied forces in Northwest Europe. He was awarded the Legion of Merit and several foreign decorations for his work. Dr. Spencer resigned his post in order to give full time to cancer education and research. The former director of the National Cancer Institute is well known in medical circles for his work in developing a tick fever vaccine. A part of his future duties will be to direct the institute's program of training young physicians in diagnosis and treatment of cancer.

Dr. Edward U. Condon, director of the National Bureau of Standards, and **Dr. Detlev W. Bronk,** chairman of the National Research Council, have accepted membership in the scientific advisory committee of Brochhaven National Laboratory. The government-financed laboratory is engaged in basic research and peacetime application of atomic energy.

Isadore Rosenfield, architect and hospital consultant of New York, and **Velez, Posada and Rodriguez, Ltda.,** architects of the Republic of Colombia, have been awarded first prize in the competition for a 300 bed Industrial Hospital at Medellin, Colombia. Sponsored by the National Association of Industrialists, the institution will be a general hospital, with special emphasis on the care of children.



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You can page doctors, nurses, supervisors and other staff personnel without delay. Voice paging in selected areas or in many hospital zones at once contacts your party . . . directs him to where he is needed . . . in a matter of seconds.

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RCA's Master Sound Control Console co-ordinates all the functions you require in one easily operated assembly. Because of its unit method of construction, it gives you all of the advantages of a "custom-made" system within the price range of regular production equipment.

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J. Walsh Stull



Paul J. McCarthy

J. Walsh Stull and **Paul J. McCarthy** have been appointed to the staff of Ross Garrett and Associates, St. Louis. Mr. Stull recently completed the program in hospital administration at Northwestern University and at the same time served as administrative assistant and director of public relations at Wesley Memorial Hospital, Chicago. Mr. McCarthy has been administrative assistant with Group Hospital Service, Inc., of St. Louis.

Dr. John L. Rice, former health commissioner of New York City, was elected president of the Public Health Association of New York at the annual meeting of the association in June.

Trustees

Hooper S. Miles, treasurer of Maryland, has been elected to the board of trustees of Johns Hopkins Hospital, Baltimore, and named treasurer of the hospital.

Samuel H. Kauffmann, business manager of the *Evening Star,* leading daily newspaper, has been elected president of the board of directors of Emergency Hospital, Washington, D. C., it was announced May 29. He will succeed **George A. Garrett** who has been named U. S. Minister to Ireland. Mr. Kauffmann has been a board member since 1938 and vice president of Emergency since 1939.

Deaths

Luther S. Hammond Jr., superintendent of Passavant Hospital, Chicago, died at the hospital June 30 after an illness of two months. Mr. Hammond had been superintendent of the hospital for the last two and a half years. Prior to that time, he had been for six years an assistant to the late Dr. Irving S. Cutter at Passavant.

A graduate of Yale University, Mr. Hammond was in the insurance business in Chicago until he entered the hospital field in 1938. He became an active member of the Chicago Hospital Council, serving on a number of its important committees and study groups. At the time of his death, he was secretary-treasurer of the council and had just submitted a report as chairman of a special council committee studying the relationship between hospitals and Blue Cross.

Mr. Hammond was 46 years old. He is survived by Mrs. Hammond, a son and a daughter.



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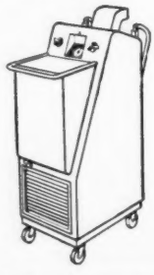
Here's Help for Busy Nurses!

Short-handed, over-worked nursing staffs appreciate the time-and-labor-saving equipment planned and produced by General Hospital Supply Service.

Two examples are our transparent plastic bassinet which eliminates the need for gauze linings, makes babies readily visible all the time from any angle, and our original Oxyhood which simplifies the effective administration of oxygen to infants. Both are light, durable, easily cleaned with green soap and water.

Like a third hand these modern units permit more effective utilization of nurses' time and energy. Write for full particulars.

The General Automatic electrically-cooled oxygen tent ends the drudgery of ice-chopping and water-bucket-handling. Sets a new standard for ease and efficiency in tent therapy nursing.



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The BOOKSHELF

THE AMERICAN HOSPITAL. *By E. H. L. Corwin, Ph.D. (Monograph Series of the New York Academy of Medicine, Committee on Medicine and the Changing Order), New York. The Commonwealth Fund,* 1946. *Pp.* 212 *and Index.* $1.50.

The top officer of the American Hospital Association preparing his presidential address and the youthful student of hospital administration writing a term paper would alike have to hunt painfully through a variety of sources to find the data which Dr. Corwin has assiduously brought together about the kinds and sizes, the auspices and the distribution of hospitals; their utilization; their huge capital investment; their tiny endowment; their incomes, expenses, costs, staffs; their management and behavior. It is not a book for the specialist who wants a lot of information about some particular group of these facts, there is not space for that, but it is a well packed small volume which

AN ANNOUNCEMENT OF BISHOP POLICY ON HYPODERMIC NEEDLE STANDARDIZATION

The Committee on Purchasing, Simplification and Standardization of the American Hospital Association has recommended a simplified list of sizes of hypodermic needles for general hospital use. This recommendation has received the approval of the American College of Surgeons.

Bishop endorses and supports this recommendation because it not only opens the way to simplified buying and stock keeping, but it also offers an opportunity for better manufacturing conditions and better service to the professions.

By concentrating production on a simplified, standardized group of sizes, definite manufacturing economics can be effected. These savings are reflected in the prices of the sizes on the simplified list.

These prices are less by 25c per dozen than the list prices for those sizes not on the simplified list.

SIMPLIFIED LIST OF HYPODERMIC NEEDLES

ITEM	GAUGE AND LENGTH	TYPE	SOME USES
1	26 x ½" R.B.	Regular Luer	Intradermal hypodermic
2	25 x ⅝" R.B.	Regular Luer	Hypodermic and local anesthesia (raising wheal)
3	24 x ¾" R.B.	Regular Luer	Intravenous (syringe) and varicose veins
4	22 x 1 ½" S.B.	Regular Luer	Intravenous (syringe) and fontanel
5	22 x 2"	Regular Luer	Anesthesia
6	22 x 3"	Regular Luer	Anesthesia
7	20 x 1 ½" S.B.	Regular Luer	Intravenous (gravity), intravenous anesthesia, intraperitoneal (Saline, Neosalversan), Wassermann
8	20 x 2"	Regular Luer	Intramuscular
9	18 x 2" S.B.	Regular Luer	Hydrocele and phleboclysis aspirating and pneumothorax blood transfusion; intraperitoneal, intramuscular and jugular
10	19 x 3"	Regular Luer	Hemorrhoidal and hypodermoclysis
11	15 x 3 ½"	Regular Luer	Aspirating
12	20 x 4"	Regular Luer	Local anesthesia hemorrhoidal an. intracardiac
13	20 x 6"	Quincke Spinal with Stylette	Local anesthesia
14	20 x 3 ½"	Quincke Spinal with Stylette	Sacral and spinal anesthesia
15	22 x 2"	Pitkin Spinal with Stylette	Children's spinal
16	22 x 3"	Spinal with Stylette	Spinal anesthesia
17	19 x 3 ½"	Regular Curved tonsil-Luer	Spinal diagnostic
18		Regular Straight tonsil-Luer	Tonsil
19		Hose hub needle Luer Taper	Tonsil
20	15 x 2" S.B.	Hose hub needle Luer Taper	Phlebotomy and blood transfusion blood bank donor
21	17 x 2" S.B.	Hose hub needle Luer Taper	Blood bank, recipient
22	18 x 2" S.B.		Blood bank, children

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everyone interested in hospitals needs to have on his shelf. If every administrator were to buy a copy for each member of his board, mark some pages (not more than 20) and send each trustee a presentation copy with a note calling attention to the markings, he might get more than his money back within two years!

Those deeply concerned with hospital problems must not expect too much. A lot of ground has been covered, but thinly cultivated. The sections on the duties and qualifications of hospital administrators and on other hospital personnel are among the few parts where the penetration is below the surface. The book is badly infected with Newyorkitis. What has been done and what can be done in the super-community at the mouth of the Hudson River are important and often suggestive for the rest of the country, but the perspective is overplayed.

Two thirds of all our general hospitals are of less than 100 beds, a fourth have fewer than 25 beds. The lack of hospitals in many rural areas is an urgent problem but is part of the much more widespread and deep seated problem of the *small* hospitals—perhaps half of all our general hospitals—which are unsatisfactory in standards, organization, methods of finance, professional and community relationships. The problems of these hospitals are not to be solved by applying New York principles to Squedunk. The Commission on Hospital Care demonstrated that. The problem has to be solved by working in and from the small community, the kind of community in which a majority of Americans still live.

"Ward" organization of services and staff is presented in this book from the point of view familiar to Eastern and teaching hospitals, not from the standpoint of most of the hospitals of this country. The major problem of integrating hospital staff services with the general medical practice of the hospital area is inadequately dealt with. The huge and urgent issues of the state mental hospitals and of our policies of hospital care for veterans should have been raised, especially in the chapter on "Retrospect and Prospect."

It is a pity that discredited statistics of a study of 1938, purporting to show that "98 per cent of the population of the entire country lives within 30 miles of a recognized hospital," should have been given weight in interpreting the hospital needs of rural areas (pp. 80, 201). It is too bad that some good tricks were missed, for example, the opportunity to urge certain improvements in governmental hospital organization, especially the appointment of nonpolitical governing boards, of which a number of excellent instances could have been cited.

It is easy to pick flaws, but reviewers are expected to use hatchets as well as butter knives. A critical attitude may be useful to readers in what someone—I think it was President Hutchins—called "the difficult task of keeping one's mind alive." A valuable compendium can rarely be also a pathfinder. Taken for what it is, the book places the hospital world in Dr. Corwin's debt.—MICHAEL M. DAVIS.

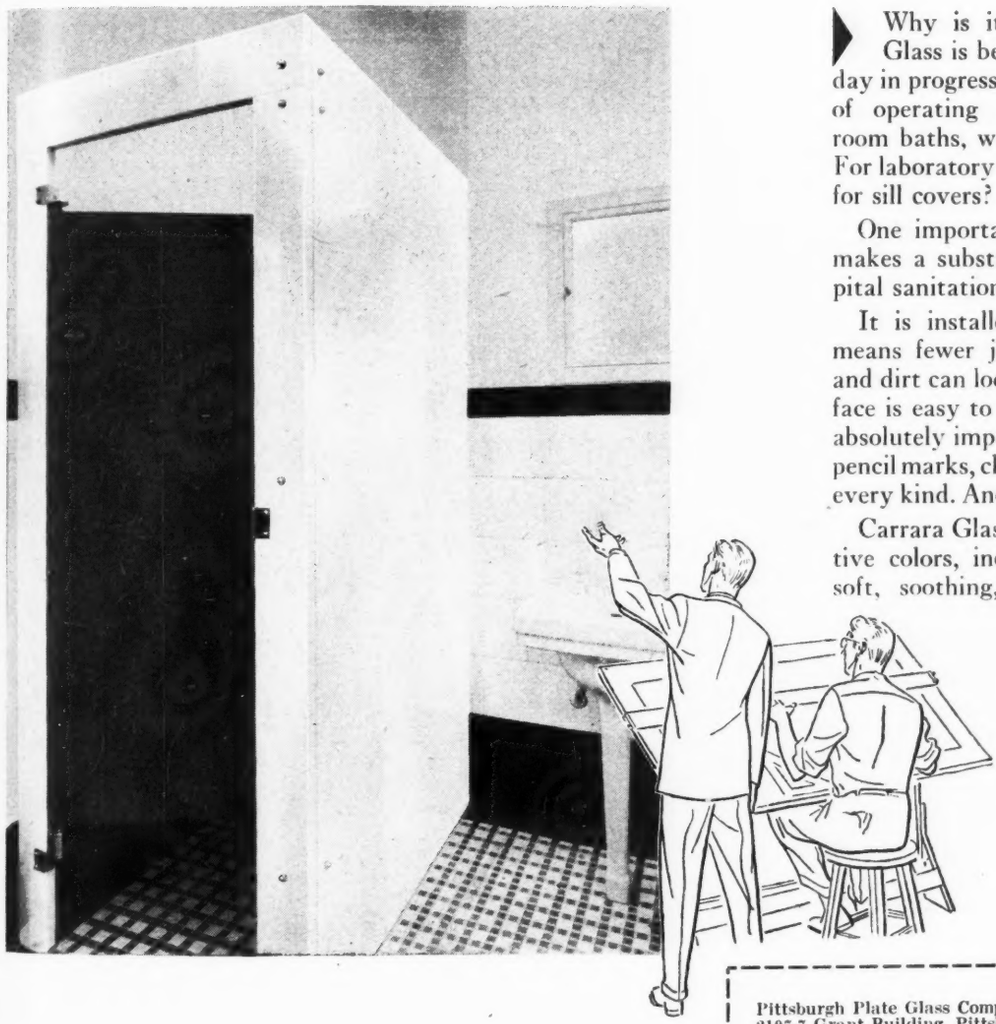
THE HOSPITAL ACT AND YOUR COMMUNITY. *Federal Security Agency: Washington, D. C. Paper.* 10 *Cents.*

This attractively produced pamphlet tells in simple outline form all that any community group or agency needs to know in order to take the first steps toward "measuring the community for a hospital" and finding out how its program fits in to the state and national plans. Copies of the booklet may be purchased direct from the Government Printing Office at 10 cents each or at $7.50 for 100 copies for distribution through state hospital and health agencies and field offices of the U. S. Public Health Service to organizations and persons interested in health, hospitals and general civic progress.



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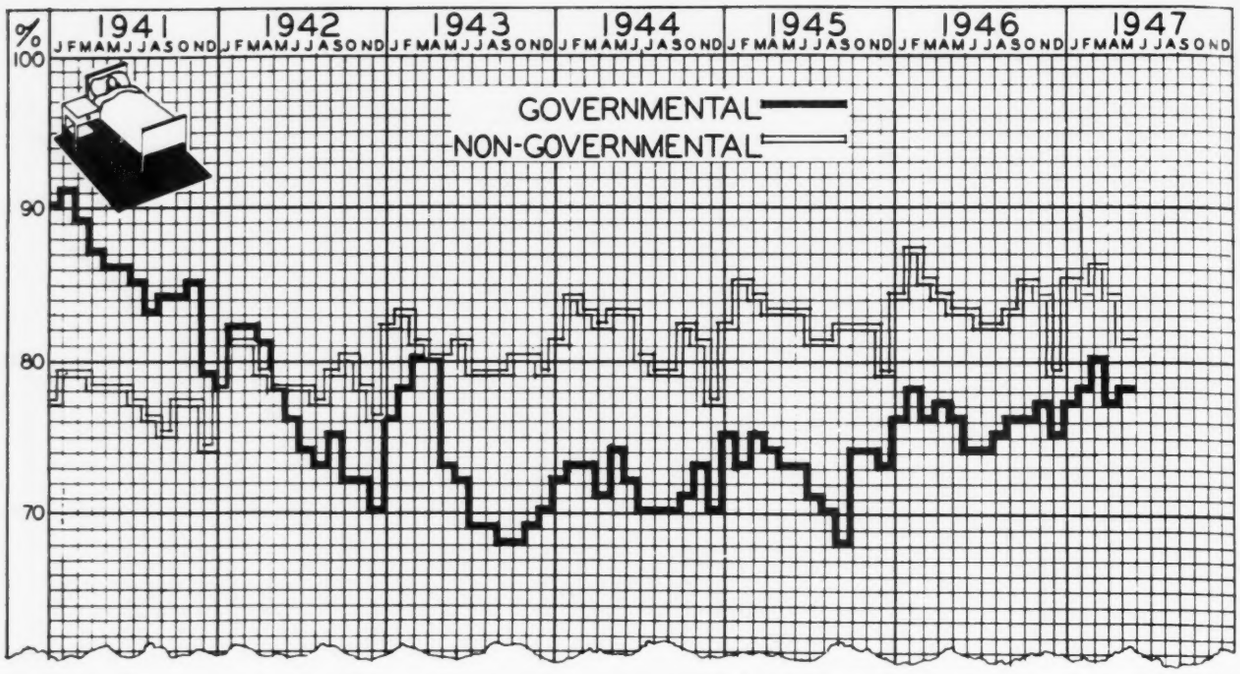
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Drop in Voluntary Hospital Occupancy Noted

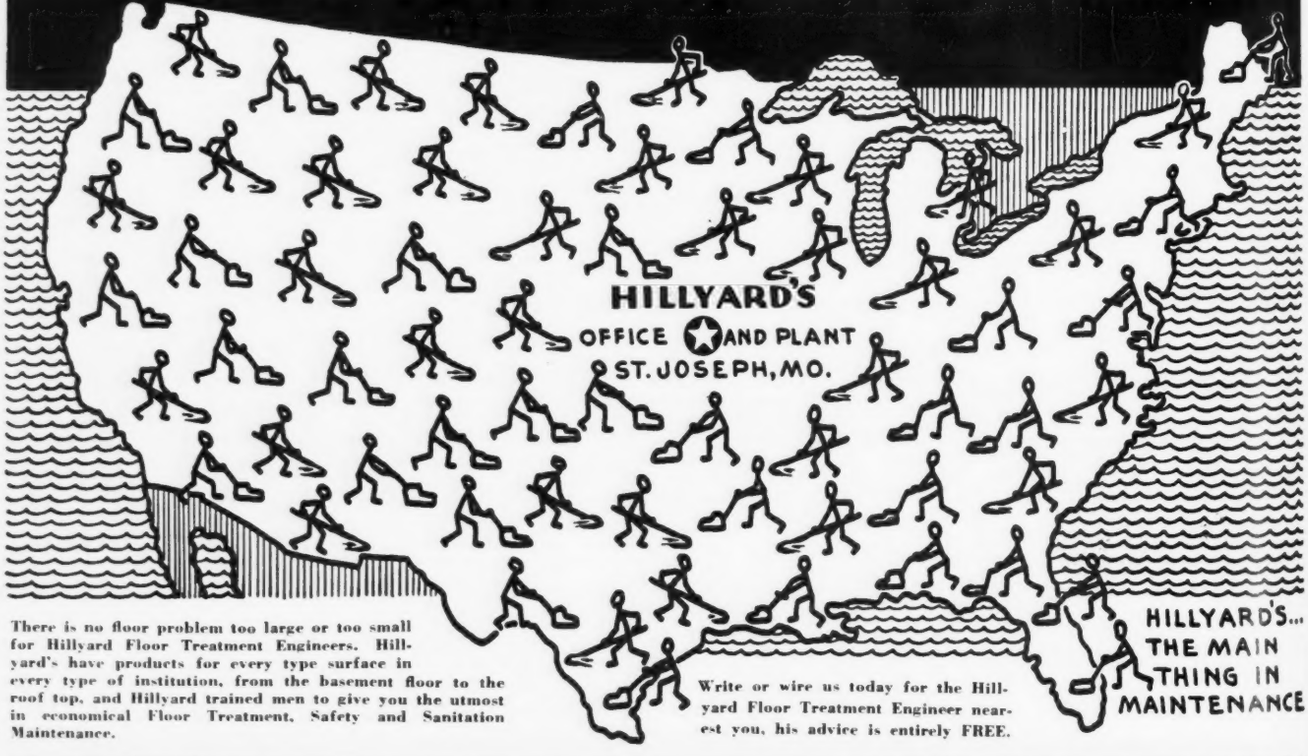


Figures on the occupancy of voluntary hospitals during May showed a decline of 3.1 per cent from the April level and 1.6 per cent from the figure reported for May 1946. The latest reports put voluntary hospital occupancy for May at 81.3.

Occupancy of governmental hospitals during May was 77.7, the same as April of this year and a 1.7 rise over the figure reported for May 1946.

Construction reports indicated that hospital building continues at a high level. A total of 33 projects was listed, with 26 reporting costs of $28,503,725. Of these, 20 were new hospitals, with 18 reporting costs of $17,938,725; 10 were additions to existing buildings, of which six cost $3,720,000, and three were nurses' homes, two of which cost $1,285,000.

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